CLOSER
TO HOME

THE REPORT OF
THE BRITISH COLUMBIA
ROYAL COMMISSION ON
HEALTH CARE AND COSTS

Canadian Cataloguing in Publication Data
British Columbia Royal Commission on Health Care and Costs.
Closer to Home

ISBN 0-7726-1426-1
Contents: v.1. Summary of the Report of the British Columbia Royal Commission on Health Care and Costs - - v.2. Report of the British Columbia Royal Commission on Health Care and Costs - - v.3. Sources for the Report of the British Columbia Royal Commission on Health Care and Costs.

1. Medical care - British Columbia. 2. Medical care, Cost of - British Columbia. I. Title.

RA412.5.C3B74 1991 362.109711 C91-092313-2

92-03654/

CLOSER TO HOME

THE REPORT OF THE BRITISH COLUMBIA ROYAL COMMISSION ON HEALTH CARE AND COSTS

the
COMMISSIONERS

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Robert G. Evans

Robert G. Evans

Marguerite Ford

Marguerite G. Ford

Kenneth J. Fyke

David R. Sinclair

William A. Webber

William A. Webber

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G. Dewey Evans	Director of Research
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TERMS OF REFERENCE

- To examine the structure, organization, management and mandate of the current health care system to ensure continued high quality, access and affordability throughout the 1990s and into the twenty-first century.

- To examine the utilization, appropriateness and efficacy of health care services, including hospital and continuing care services, medical services and prescription drug programs and growth rates in these programs to identify possible options and efficiencies that would allow for improvements in the quality of care and better cost management.

- To examine the costs associated with each of the health care system's major elements and the current methods of funding and reimbursement and to identify possible options, including alternative delivery models, that would allow for better allocation and use of available resources.

- To examine the physician, nursing and other health care professional manpower requirements of the Province of British Columbia.

- To examine opportunities to further the health of British Columbians through health promotion, health protection and the implementation of healthy public policies.

- To examine existing legislation to ensure an appropriate statutory framework consistent with the achievement of an economical, efficient and effective system of health care and health promotion.

- To report findings and make recommendations with particular respect to structural changes, utilization management, application of technology, funding and reimbursement methods as well as service effectiveness and management efficiencies of the health care system.

CLOSER TO HOME

This report, *Closer to Home*, is divided into three volumes. The first is a summary designed to provide an overview of the royal commission's report. That volume will give the general reader an understanding of the ways in which the health care system should be restructured as medicare in British Columbia enters its second quarter century.

The second volume of *Closer to Home* is the main body of the report. This volume sets out the specific recommendations of the Royal Commission on Health Care and Costs. It does not contain a single list of all of the commission's recommendations; these should be read in context to avoid a misinterpretation of the commission's intentions.

Volume Three of *Closer to Home* contains the bibliography for the royal commission's report, as well as a list of the names of the groups and individuals who made presentations to the commission. It also contains information on where the commission's material and data base are stored.

The names of all ministries, services and programs mentioned in these three volumes are based on the information available in May, 1991.

Health

Many people have adopted the 1984 World Health Organization (European Region) definition of *health* as *the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment.* Others support the 1986 Ottawa Charter for Health Promotion definition of *health* as *a resource for everyday life.*

The commission understands these definitions and our experience has convinced us that the social and economic environment is a critical determinant of health. For the purposes of this report, however, we have concentrated on the narrower fields set out in our terms of reference. We believe that this focus is essential and that it has resulted in recommendations which are both pragmatic in nature and achievable in scope.

Children and Youth

Only one chapter of *Closer to Home* focuses on the health of children and youth, yet the whole of this report is about the system of care that they will inherit. British Columbians have no greater responsibility than to secure a healthier and happier future for them.

Volunteers

The commission would like to state openly its profound respect for the large number of people in this province who volunteer their time and energy to their community. All of us benefit from their selfless contribution. All of us should support their work.

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PART A: INTRODUCTION

We recognize that the well-being
and happiness of society is simply the sum total
of the well-being and happiness
of its individual members.
It is clear that the well-being of a proportion
of the population at any given time
is seriously curtailed because
of mental or physical disease or impairment that,
strictly by the laws of chance,
could strike any one of us.

The Royal Commission on Health Services,
1964. Volume 1.

THE REPORT

An unfortunate feature of conducting a commission is that it is bound to focus on those things that need to be changed. After reading this report, the reader might conclude that we do not think that British Columbians share a high standard of health care. But that would be a mistake.

In the past 18 months, the commission has seen many examples of excellent work at all levels in the system. We have seen caring and compassionate *home care workers, efficient and effective emergency departments, outstanding organ transplant teams and numerous examples of exciting, progressive research. Health care in British Columbia is part of a global system that depends on ideas and techniques developed and tested in many countries. It is a dynamic system, and the people who work within it recognize their obligations to make a contribution to the global community. The commission supports excellence and innovation at all levels and encourages the development of new knowledge and programs. Where British Columbians have special expertise, they should provide that care to people from elsewhere as long as they first satisfy the needs of the people of the province.

We are unanimous in our opinion that the system of health care in this province is one of the best, and quite possibly the best, in the world. We do not make this claim lightly or to soothe anyone's temper. ***We have talked to representatives from many different health care systems and we have not found a system that we would accept in exchange for the one currently in operation in British Columbia***.

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and the Health Care System 7

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It is of course,
a lot easier
to criticize
the health care system
than to devise
a better one.
HCP-118

Because of the breadth of the commission's terms of reference and the limited time available, we have not been able to examine everything which falls within our mandate. Instead, we have tended to concentrate our efforts on understanding and reorganizing the structure of the health care system. We have, on occasion, suggested that a topic, such as no-fault insurance, is one that warrants further study by another body. There are also a number of areas in which our own studies have not led to any specific recommendations and, therefore, are not discussed in this report.

In the same vein, we have not attempted to deal with issues that have been dealt with or are being dealt with by other commissions or committees. For example, British Columbia needs new legislation to support people who are mentally or physically incapable of making or communicating their own decisions. The current legislation, the Patient's Property Act, has been described to us as expensive, excessive, inflexible and inhumane. At the same time, no mechanisms currently exist to limit a court-appointed guardian's powers to only those decisions necessary to ensure the personal or financial security of the incapable person.

The commission thinks that people should be allowed to give direction for their future care, or to appoint representatives to make health care decisions on their behalf, in the event that they become incapable of making those decisions for themselves. Such a representative should be able to make the same sorts of decisions about the incapable person's health care as that person would have made. But we expect these issues to be dealt with through the Guardianship Committee, formed in the spring of 1989, and its Project to Review Adult Guardianship. Therefore, we have not made specific recommendations about substitute decision-making.

Many of the *submissions ask the commission to provide special help for members of a particular group or people suffering from a particular disease or condition. Many request special provisions under Pharmacare or Home Care for the groups that they represent. But we believe that the *best care possible* can and should be provided to all British Columbians, regardless of their age, sex, place of origin, disability or illness.

This report has not been written for the benefit of researchers or experts. It has been written for the people of British Columbia and their elected representatives. Those people with a particular interest in research and statistics will find a complete listing of the documentation on which we have based our recommendations in Volume Three of this report.

The Five Principles

In 1984, the Canada Health Act defined and reaffirmed the five principles of medicare as expressed in The Royal Commission on Health Services, 1964, by

Justice Emmett Hall. The British Columbia Royal Commission on Health Care and Costs fully endorses and supports these principles, which are:

- comprehensiveness
- universality
- portability
- accessibility
- public administration.

Comprehensiveness means that all medically necessary health care services provided by physicians or in hospitals must be covered by provincial health care plans. Most provincial governments allow physicians to decide what is medically necessary.

Universality requires that 100 percent of the residents of a province be entitled to insured services on uniform terms and conditions. Section 10 of the Act appears to prohibit the payment of premiums as a prerequisite for eligibility.

Portability applies host-province rates to health care services provided elsewhere in Canada and establishes national standards for out-of-country benefits. It also requires the province-of-origin's consent for the coverage of elective services provided to a resident outside the province.

Accessibility means that provincial health care plans must provide for insured health services on uniform terms and conditions and must not impede or prevent reasonable access to those services by any means. It recognizes that reasonable compensation must be paid to practitioners who bill the provincial plans in accordance with a tariff approved by the province, and addresses the issue of payments to hospitals to cover the cost of insured services. It also establishes that procedures must be in place for negotiating medical insurance plan payments to practitioners.

Public administration refers to government involvement in health insurance. The Act describes the elements of public administration as being:

- administration of the insurance plan without profit
- run by a public authority appointed or designated by the provincial government and responsible to the government
- regular audits of the public authority.

There is nothing in the Act which appears to prohibit contracting out any health care services to private industry.

To date, no Canadian province has confirmed the five principles of medicare by enacting them in legislation. Every province has taken steps to discourage or prevent extra-billing and has removed hospital user fees, but none has gone further. ***We believe that it is important that the BC government take the first step and make these principles an integral part of BC law***.

Therefore, the commission recommends that:

1. the government of British Columbia confirm the five principles of medicare, as described by the Canada Health Act, 1984, by enacting them in legislation.

This is true security - the preservation of principles.
UNI-083

* GLOSSARY

Guidelines

By talking with British Columbians and listening to their concerns and aspirations, we have arrived at a set of simple guidelines which, along with the five principles of medicare, we believe are necessary components of a health care system. We think that anyone studying the matters brought before us would come to the same conclusion.

- *Closer to Home*

Medically necessary services must be provided in, or as near to, the patient's place of residence as is consistent with quality and cost-effective health care. For example, more of the medical services needed by the residents of Tofino should be provided in Tofino, and fewer in Port Alberni; more of the medical services needed by the residents of Port Alberni should be provided in Port Alberni, and fewer in Nanaimo; more of the medical services needed by the residents of Nanaimo should be provided in Nanaimo, and fewer in Vancouver.

- *The Public First*

Public servants and professional colleges must always put the public interest ahead of their own or their members' interest.

- *Outcomes*

The focus of the health care system must be on providing those services which improve health outcomes. These outcomes must be defined, measurable, subject to analysis and able to be independently evaluated. Services which cannot be shown to improve health should not be funded by the health care system.

- *Community Involvement*

Decisions should be made as close to the community level as possible; local people must be allowed to shape the local system of health care delivery. Government should be prepared to fund coordinators and to encourage the creation of advisory boards. If it attempts to force local citizens to participate in schemes designed by the Ministry of Health, then the boards will be failures.

- *Funding*

The people of British Columbia must reform and improve the health care system within the current levels of spending. At the same time, government must recognize that, although provincial revenues may vary, sickness is a constant factor. There must be less variability in the funding of health care than there is in other areas of the provincial budget.

- *The Jericho Process*

Administrative walls within the Ministry of Health, among ministries, health care institutions and organizations, and between all of these groups and educational institutions, must be broken down in favour of an integrated health care system.

- *Necessary Education*

All tasks within the BC health care system should be open to people with the education necessary to provide high-quality care. People should not be barred from performing a task because they lack education which is not necessary to performing that task and does not demonstrably improve health. The "credentialization" of positions within the health care system must be stopped.

- *Volunteers*

Citizens who volunteer help are a significant part of the health care system and are vital to developing new programs. People have the right to participate directly by volunteering their time in appropriate roles. These include governance, patient service and advocacy, but not replacing paid staff. Neither should paid staff or their representatives seek to replace volunteers. There should be some volunteer control over the jobs that they do. During labour disputes, essential services agreements should identify appropriate volunteer roles.

- *Openness*

Except where privacy and confidentiality demands otherwise, all of the information on health and health care gathered by public servants in ministries and in publicly funded institutions should be available to the public and to researchers.

Changing Roles and the Health Care System

In the past, people relied on physicians to provide or direct almost all of their health care. There were few machines, few drugs and few specialists. The family physician was given and assumed responsibility for the health of most people, the direction of nurses and volunteers, and the control of the hospital system. Taxpayers were involved, but only marginally; government was on the fringes and the responsibility for paying for medical services was borne by the individual.

But all of that has changed.

Women no longer accept the roles that the traditional health care system once expected them to play. There are now almost as many specialists as there are family physicians in BC. Machines and medications have fuelled a medical revolution. The practice of medicine now employs many highly trained people who use expensive technical devices that not only aid physicians, but, in some instances, replace them.

Nor is the physician now the only person qualified to decide on what treatment or studies are appropriate for a patient. In the past, no one else was involved in those questions but now there are technicians, therapists, pharmacists and, increasingly, community groups, volunteers and informal caregivers. There are also taxpayers.

Health care in British Columbia employs more than 60,000 people and costs more than ***$850,000 an hour,*** the majority of the money raised through taxes and spent through the Ministry of Health. In our society, the government represents the people. It has the legislated responsibility to raise taxes and use these funds to run the finances of the province as directed by the people. That responsibility requires government's involvement in, and supervision of, the health care system.

Possibly more than any other single factor, this involvement of government has changed the role of the physician and the individual in the control of the health care system. The constraint once found in the individual's ability and willingness to pay has been replaced by the constraint of collective bargaining and the government's ability and willingness to pay.

It is often difficult to accept a change in role, particularly for professional people. It can also be difficult for the public to recognize that certain roles and responsibilities, including their own, have changed. But changes have occurred and they cannot be reversed. What is left for all of us is to reorganize the system in the light of those changes. No doubt some people will find this difficult to accept.

This is a time
of change,
and people do not like
to change.
This is human nature.
UNI-041

When you are in need
of health services
you need
to be respected
and you need to be
treated with dignity
Native Health Roundtable

Seniors and the Health Care System

Because of the recent work by the BC Task Force on Issues of Concern to Seniors, and because such a large number of the topics discussed in this report relate directly to seniors, we have not written a separate chapter for them. Instead, we think that the reader should be aware continually of the effect an aging population has upon the mandate, structure and funding of health care services. We also want to emphasize that independence, self-esteem and the quality and value of life are not the concerns of any one age group or sex. They are important to everyone.

The need to move medical services closer to home and the need to involve the community in its own health care are particularly important issues for seniors. Policies and programs which help people in communities to look after their neighbours are important to this process and require a system in which information, subject to the requirements of privacy and confidentiality, is freely available. ***The government must not discourage neighbourly support***.

During one of our public hearings, the Vancouver Health Department described a framework for *health promotion among older adults. This framework emphasizes an approach to health care which involves the community in identifying and responding to its own needs. We agree with this approach. Bearing this in mind, we have concluded that health care services and programs for seniors and the frail elderly should be characterized by:

- the maximum degree of autonomy
- a continuum of care including the home, the community and, if necessary, institutions.

•Toward a Better Age

We have reviewed the report of the BC Task Force on Issues of Concern to Seniors, *Toward a Better Age*, and considered the 21 recommendations set out in the section titled "Toward Health and Wellness". Many of these recommendations touch upon or overlap recommendations made in this report. The Task Force supported multi-level health care facilities, psychogeriatric care, training in psychogeriatrics, training in remote parts of the province, assisted travel, hospital outreach and hospital community programs, home support, *palliative care, drug and alcohol programs, and programs that encourage good health.

We agree with the thrust of these recommendations, subject to two general cautions. Emphasis should be placed on reallocating funds rather than adding on new expenditures, and there must be an appropriate analysis of health outcomes.

Therefore, the commission recommends that:

2. **the provincial government, the hospitals and others involved in giving care to seniors work towards the implementation of the health recommendations of the Report of the British Columbia Task Force on Issues of Concern to Seniors, *Toward a Better Age*.**

•Demography

Figures published by the Department of Finance and Corporate Relations, Planning and Statistics Division, show that, as of 1990, approximately 409,000 people, 13 percent of BC's population, were 65 years old or older. It is expected that by the year 2016 this group will number 862,400 persons or over 18 percent of the provincial population (See Figure 1).

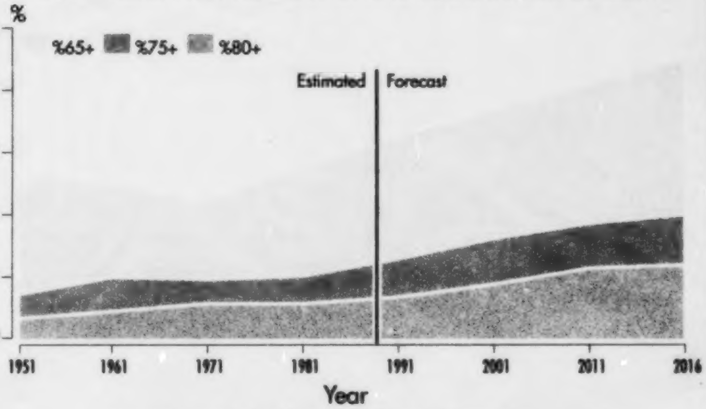
This is due, in part, to the fact that the "baby boom" of the post-war years was followed by the largest decline in fertility rates in Canadian history (See Figure 2). This means that the proportion of children under 15 in BC has rapidly declined over the past two decades, a trend which the "echo" boom of the last few years has slowed but not stopped. As children now represent a smaller proportion of the population than they did 20 years ago, the proportion formed by all the other groups, including seniors, has gone up.

Although the province has a reputation as a favoured destination for retired people, only 7.4 percent of the net migration to the province (in-migration less out-migration) since 1961 was over 65. This means that migration has reduced that proportion of the population over 65 years of age.

Life expectancy has also increased. Fewer than six out of ten people born between 1920 and 1922 reached 65 years of age. By 1985 to 1987 this figure had climbed to eight out of ten, with life expectancy for women increasing more rapidly than for men. One result of this sex-related difference is that there are twice as many women over 85 as there are men in this age group.

As a group, seniors are poor; their median income is 44 percent below that of the general population. As private and public pensions become widely available, this situation should improve. But as the proportion of the population over 65 increases, a larger number of non-income-earning people will be dependent upon a smaller group of income-earning people for support, understanding and care. This carries important implications for the future of British Columbia's seniors and the nature and structure of the health care system.

FIGURE 1
BC SENIORS AS A PERCENT OF THE TOTAL BC POPULATION



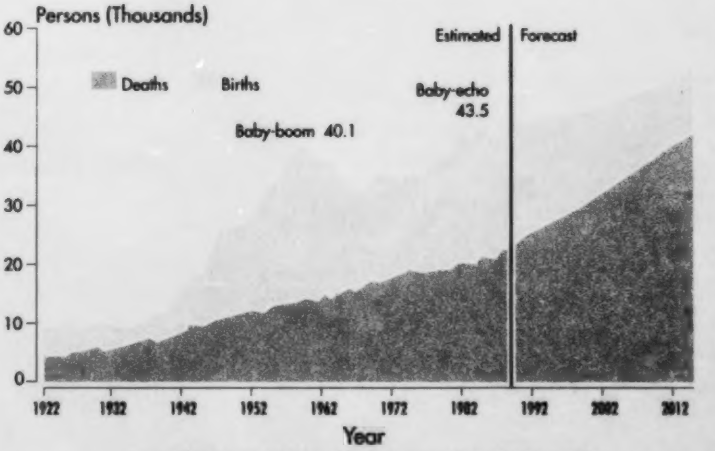
Source: Planning and Statistics Division, Ministry of Finance and Corporate Relations, 1990
British Columbia Population Forecast: 1990-2016

There has been a wide-ranging discussion for a number of years about the threat an aging population poses to a health care system. As these discussions have pointed out though, it is not only the increasing proportion of seniors, and particularly the frail elderly, in the population that increases costs, there is also an increase in the average senior's use of the health care system.

In the Creston Valley the population is 68% over 65.
HOS-179

Population over 65 in Richmond? Approximately 9%.
HOS-089

FIGURE 2
BRITISH COLUMBIA BIRTHS AND DEATHS



Source: Planning and Statistics Division, Ministry of Finance and Corporate Relations, 1990
British Columbia Population Forecast: 1990-2016

TABLE ONE
MEDICAL SERVICES UTILIZATION BY AGE
1974/75 and 1985/86
Medical Services Billings per Capita
(constant dollars)

	1974/75 $	In 1985/86 Fees $	% INCREASE	AVERAGE ANNUAL INCREASE
GENERAL PRACTICE				
0-64	33.78	41.41	22.59	1.87
65-74	53.89	63.90	18.57	1.56
75+	66.59	96.79	45.35	3.46
All	36.22	45.57	25.83	2.11
MEDICAL (excl. anaesthesia)				
0-64	8.54	13.71	60.54	4.40
65-74	16.63	31.12	87.11	5.86
75+	14.85	34.79	134.32	8.05
All	9.26	15.94	72.27	5.07
SURGICAL (incl. anaesthesia)				
0-64	18.03	22.88	26.90	2.19
65-74	41.95	58.20	38.74	3.02
75+	40.44	73.42	81.55	5.57
All	20.28	27.76	36.89	2.90
RADIOLOGY & PATHOLOGY				
0-64	11.26	20.65	83.39	5.67
65-74	23.69	41.87	76.77	5.32
75+	16.19	43.66	169.72	9.44
All	12.17	23.25	91.05	6.06
OTHER				
0-64	0.31	0.80	158.06	9.00
65-74	1.08	2.36	118.36	7.36
75+	0.75	2.02	170.86	9.48
All	0.37	0.97	159.63	9.06
TOTAL				
0-64	71.93	99.44	38.25	2.99
65-74	137.25	197.46	43.87	3.36
75+	138.31	250.68	80.59	5.52
All	78.29	113.49	44.96	3.43

Source: Canadian Medical Association Journal, Vol. 1, #1, July 1:1989:39-45

In these times of rapidly expanding population, changing technologies and rising cost, innovative solutions are a necessity, and creative alternatives a must.
HOS-093

Many provinces have found that a rapid increase in the services provided to each patient coincides with the increase in the supply of physicians in Canada. However, there is currently no way to decide whether or not the increasing use of the health care system by the elderly is an appropriate response to increased health care needs. When recent age and sex adjusted medical use rates are analyzed according to projections for the age and sex distribution of the population, yearly per capita rates of increase in the use of medical services averaging only 0.4 percent are predicted for the next two to three decades. This rate is lower than the province's previous economic growth, but it will become significant if the province's economic growth continues to be close to zero.

Between 1974-75 and 1985-86, *fee-for-service billings by physicians increased $595 million: from $184 million to $779 million in current dollars. Of this increase, $259 million resulted from increases in fees which rose in line with inflation, $94 million resulted from the increase in the population, and $24 million resulted from the fact that the population is older and, therefore, needs an increased amount of certain types of procedures. The remaining $218 million came from increases in the use each person made of the health care system. People aged 75 years or more made up about 4 percent of the population between 1974/75 and 1985/86, but they accounted for about 16 percent of this $218 million.

Table 1 shows that, for example, per capita billings in constant dollars for radiology and pathology for those aged 75 years and over increased by 170 percent between 1975 and 1986. The increase in per capita use for the entire population for the same period of time was only 91 percent. Similarly, the increase in use of general physician services for those aged

75 years and over was 45 percent per capita, while the increase for the whole population was 26 percent. Other provinces have experienced similar trends.

Elsewhere in this report we have recommended steps to analyze, on the basis of an appropriate data bank, rates of use and health outcomes for seniors. We will have a much better understanding of how an aging population affects our province when this analysis is complete. The importance of this information to the future of health care in BC cannot be overestimated, particularly in light of the province's economic profile.

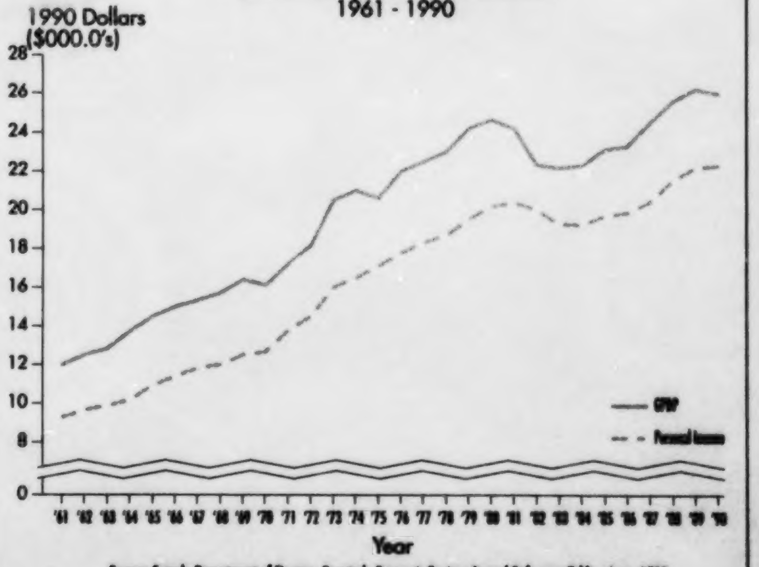
Economic Profile

The cost of health care is usually described in relation to the budget of the provincial government, because nearly 70 percent of all health care expenditures are paid for through the provincial government. Advocates of new programs or expanded services want government to increase its spending; opponents worry about the level of taxation and the size of the provincial deficit. But government, though often at the centre of the stage, is only a part of the overall provincial economy. Its estimated expenditures in 1990/91 were $15.3 billion, less than one-fifth of the $81.1 billion in economic output and income (Gross Provincial Domestic Product) generated in the province as a whole. It is the size and rate of growth of this latter amount which determines British Columbians' ability to pay for health care, and from which the revenues of the provincial government are drawn.

If the provincial economy is healthy, then government revenues will be ample and the health care system can maintain itself, or expand without straining financial resources. But if the economy stagnates or declines, the government's revenue is reduced and some combination of deficits, increased taxes and program cutbacks follows. "Privatization" of expenditures is not a way out of this circumstance. In the face of slow growth, transferring the costs of programs from government to private budgets does not make those programs more affordable, it just charges them to someone else.

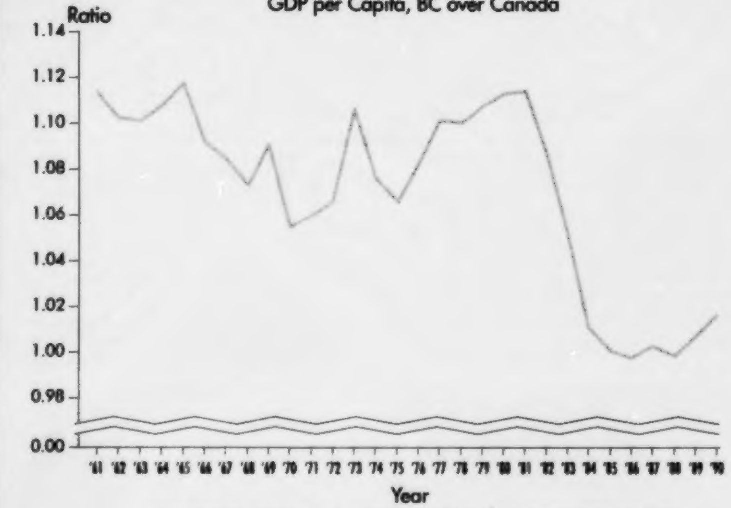
In BC, the central economic fact of the last decade has been the decline in the rate of growth of the provincial economy. As shown in Figure 3, 1961 to 1981 was a period of sustained, rapid growth. The Gross Provincial Domestic Product per capita (adjusted for inflation) grew at an average annual rate of 3.7 percent. But the 1980s began and ended with recession, and the recovery in between was slow and weak. From 1981 to 1990, the average annual rate of growth in output per person was only 0.5 percent.

FIGURE 3
BC REAL INCOME PER CAPITA
1961 - 1990



Source: Canada Department of Finance, Quarterly Economic Review, Annual Reference Tables, June, 1990

FIGURE 4
RELATIVE INCOME IN BC
GDP per Capita, BC over Canada



Source: Canada Department of Finance, Quarterly Economic Review, Annual Reference Tables, June, 1990

Falling growth rates have been a source of concern in a number of countries over this period. But the BC experience has been unusually severe relative to the rest of Canada. As Figure 4 shows, income per capita in the early 1980s fell sharply in BC relative to the Canadian average, and has not recovered since. After decades of enjoying incomes which were, on average, about 10 percent above the Canadian average, British Columbians are now down in the middle of the pack.

The government's first response to the recession of the early 1980s was to try to maintain its past spending patterns. For this reason, as Gross Provincial Domestic Product fell, the share accounted for by government spending rose from about one-sixth of the provincial economy to just under one-fifth. During the subsequent recovery, this share fell back, but remained above its pre-recession level. The government budget moved into deficit at the beginning of the decade and has remained there almost ever since.

Table 2 shows the balance of provincial general fund revenue and expenditure from 1978/79 to 1991/92. The impact of the very severe 1982 recession and its aftermath is apparent in the series of annual billion dollar deficits from 1982/83 to 1986/87.

By initially treating the recession as temporary, the government's spending on health care increased from just over 4.5 percent of Gross Provincial Domestic Product in 1979 to nearly 6 percent by 1981. But, as it became clear that recovery would be slow, and perhaps incomplete, spending controls were introduced and the share of Gross Provincial Domestic Product devoted to health spending remained roughly constant for the rest of the decade (See Table 3).

The weak economic recovery in the late 1980s, combined with the restraint policies of the provincial government, moved the provincial budget back to a small surplus. But the 1990/91 recession has brought back billion-dollar deficits.

Current forecasts for an early recovery from this latest recession predict growth rates during the first half of the 1990s far below those achieved in the 1960s and 1970s – not much above 1 percent per year at best. If these forecasts turn out to be accurate, there will be little or no scope for overall expansion in government expenditures, other than through increases in taxation or debt. The federal Government Expenditure Restraint Act of June 1990, discussed in ***Protecting the Principles of Medicare***, further narrows the province's room for fiscal manoeuvres by reducing the level of federal cash transfers for health and education. These transfers made up about $2 billion of BC government revenues in 1990/91.

In this environment, program expansion in health care, or anywhere else, will require shifting resources from other programs. But the record suggests that actually transferring resources is difficult. Even pronounced changes within the health care sector tend to be cancelled out over time.

Between 1980/81 and 1981/82 there was a large and sudden swing of about 3.5 percent of the provincial health budget from hospitals to physicians (See Table 4). But this has slowly been reversed, and by 1990/91, the hospital share was just above its 1980/81 level. A similar fall and rise occurred for Continuing Care; the share at the end of the decade is almost the same as at the beginning. Payments to physicians and others through the Medical Services Plan (MSP) have declined throughout the decade, after their initial surge, but until 1989/90 were still above their share at the beginning. Community and Family Services have had a sustained gain during this period, from just over 5 percent to just over 7 percent, which represents a large change for a small set of programs, but not a major reallocation of the health care budget.

Thus, while each sector share fluctuates from year to year, over a period as long as a decade they even out. Even the share of provincial government spending going to health is almost constant – between 30.6 percent and 33.2 percent – and the share of the provincial product going to government spending has fluctuated only with the business cycle. It appears, therefore, that in a zero growth environment, each program has managed to hold on to its share. In the Chinese idiom, each group of providers has received an unbreakable *iron rice bowl.*

If slow overall growth continues through the 1990s and no changes occur in the organization of the delivery of health services in BC, this rigid pattern will presumably continue. Under these conditions, the money available for health care will only increase if the province goes further into debt, or increases taxes. We do not believe that the people, or the government, of British Columbia would find either of these options acceptable. But the commission has been told that there are new priorities that need to be met. If they are to be met – and we believe they should – then the inflexibility of the past cannot continue. Some shares must fall, some rice bowls must be broken.

TABLE 2
BRITISH COLUMBIA GENERAL FUND REVENUE* AND EXPENDITURE
(Current $ in millions)

Fiscal Year	Revenue $	Expenditure $	Surplus/ (Deficit) $
1991/92 (E)	15,311.0	16,545.0	(1,234.0)
1990/91 (F)	14,382.0	15,293.0	(911.0)
1989/90	13,497.1	13,412.7	84.4
1988/89	12,261.2	11,990.4	270.8
1987/88	11,006.6	11,080.1	(73.5)
1986/87	9,415.0	10,575.7	(1,160.7)
1985/86	9,097.0	10,063.4	(966.4)
1984/85**	8,773.5	9,767.4	(993.9)
1983/84	7,344.3	8,356.4	(1,012.1)
1982/83	6,529.1	7,513.3	(984.2)
1981/82	6,903.5	7,087.5	(184.0)
1980/81	5,802.7	6,095.5	(256.8)
1979/80	5,704.8	5,163.0	541.8
1978/79	4,704.3	4,433.8	270.5

* Revenue does not include (exclude) transfers from (to) the budget stabilization fund.

** From 1984/85 onwards, a number of revenue items such as MSP premiums which were previously netted off from expenditures, have instead been added to revenues.

E - ESTIMATES F - REVISED FORECAST

Source: BC Ministry of Finance and Corporate Relations, Annual Budget

British Columbians can be healthier and not poorer, if we have the will to change.
PRO-001

TABLE 3

PERCENT OF THE GROSS PROVINCIAL DOMESTIC PRODUCT

Dedicated to Health Care (BC 1981-90)

Year	MOH Health Care Dollars $	GPDP $	% GPDP on Total Health Care	% GPDP on MOH Health Care
1990	4,803	81,085	n/a	5.92
1989	4,383	76,332	n/a	5.74
1988	3,930	69,291	n/a	5.67
1987	3,627	62,866	8.88	5.77
1986	3,382	57,347	8.95	5.90
1985	3,102	54,499	8.57	5.69
1984	2,986	51,119	8.80	5.84
1983	2,859	48,151	8.83	5.94
1982	2,709	46,115	8.60	5.87
1981	2,394	44,691	7.88	5.87
1980/81	1,956	38,239	7.67	5.12
1979	1,518	33,360	7.02	4.55
1978	1,318	28,732	7.09	4.58

Source: BC Ministry of Health; Statistics Canada; Health and Welfare Canada; National Health Expenditures in Canada

TABLE 4

BRITISH COLUMBIA DISTRIBUTION OF PUBLIC EXPENDITURE

Fiscal Year	Prov. Gov't as % of GPDP	Min.of Health as % of Gov't	HEALTH PROGRAMS AS % OF MINISTRY Hospitals	MSP	Continuing Care	Other
1990/91	18.8	31.5	49.6	25.1	10.2	15.1
1989/90	17.7	32.5	48.5	26.9	9.8	4.8
1988/89	17.1	33.2	48.2	27.9	9.3	14.6
1987/88	17.7	32.6	47.9	28.3	9.1	14.7
1986/87	18.6	31.7	47.1	29.2	9.2	14.5
1985/86	18.5	30.8	46.5	29.5	9.6	14.4
1984/85	19.1	30.6	46.4	29.8	10.4	13.4
1983/84	19.3	30.7	46.5	30.2	11.2	12.1
1982/83	18.8	31.3	47.6	30.1	10.5	11.8
1981/82	16.4	32.7	45.9	31.0	11.2	11.9
1980/81	16.3	31.4	49.3	27.5	10.5	12.7

Source: BC Ministry of Health; Canada Department of Finance, Quarterly Economic Review

A Provincial Health Council

The system of health care which we have studied for the past year and a half developed from various programs and policies which were created or changed to meet the political, as well as the medical, needs of the day. There has never been an overall plan, and, quite naturally, the structure that has evolved lacks coherence and, sometimes, logic. It also lacks the ability to assess itself, to objectively judge how just, efficient and effective it is in providing health care.

According to a number of submissions to the commission, the province needs the guidance of a permanent, independent council. In our opinion, such a council should be able to oversee the total health care system and be able to review the policies, plans and programs of the Ministry of Health, or of any other public or private body whose actions affect the health of British Columbians. It should be able to inform the public on how well the government is meeting the health care needs of the province and, as one commissioner put it, "soften the political side" of contentious questions, bringing its influence to bear upon difficult, high-profile issues. ***It must be completely independent of the government, the Ministry of Health and the health care industry***. It should:

- enunciate specific goals for the health care system
- evaluate information to determine the degree of progress toward reaching these goals
- advise the government, when requested or on its own initiative, on contentious issues
- review and comment on the health policies and plans of the Ministry of Health, or of other ministries
- assess the effectiveness of all parts of the health care system, including the evaluation component
- ensure that authoritative health information is easily available to the public
- direct the provincial health officer to investigate or research any public health concern.

The development of an articulated vision and a clear direction for the health care system of the province is a first prerequisite for achieving improvements in its delivery and cost-effective management.
SOC-006

But we want to be perfectly clear: ***the royal commission does not question the ultimate power of the legislature to make decisions about the health care system. That power is at the heart of our democratic system and should not be challenged.***

We considered the possibility of a medical ombudsman's role for such a council, but we have decided the role should reside elsewhere. The current Ombudsman's Act, passed in 1979, contains provisions, as yet unproclaimed, that would extend the Ombudsman's authority to hospitals, boards of management of hospitals, and to governing bodies of professional and occupational associations. These provisions would not displace the responsibility of colleges for professional matters, but they would permit investigation of complaints about the health care system and report on how it provides services. We are concerned about creating another bureaucratic office and we are persuaded that there is benefit in concentrating the ombudsman's role in an office which has already established its legitimacy.

Therefore, the commission recommends that:

3. sections 10 and 11 of the schedule to the Ombudsman's Act be proclaimed.

If a health council is to have authority and credibility, the selection of its members and Chairperson will be critical. They must be independent, objective and influential, have security of tenure, a small staff, the power to contract for services and the responsibility to make an annual public report. They would need to have access to all of the information available to the Ministry of Health and other ministries, institutions and organizations.

It is time for such a council. ***It must be a creature of and report to the Legislative Assembly, not the Ministry of Health***.

Therefore, the commission recommends that:

4. a Provincial Health Council be established, and that

- **a. the Provincial Health Council consist of six members, appointed for three year terms, with two terms expiring each year. The first Council should consist of two members appointed for three years, two members appointed for two years, and two members appointed for one year. No member may serve for more than six years;**
- **b. members be appointed by the Lieutenant Governor on the recommendation of the Legislative Assembly;**
- **c. the Legislative Assembly recommend for appointment persons who have been unanimously recommended by a special legislative committee. No person actively involved in the delivery of health services shall be appointed;**
- **d. the special legislative committee recommend one of the six members to be appointed chairperson, and to serve on a half-time basis. The other members shall serve on a part-time basis;**
- **e. the council be empowered to appoint appropriate staff, and authorized to contract for research or other services; and**
- **f. the council table an annual report with the Legislative Assembly.**

The balance of this report should be read and considered in light of this recommendation.

PART B: ORGANIZATION

Moving health care closer to home will mean reorganizing the present health care system.

As we examined the hundreds
of briefs with their thousands of recommendations
we were impressed with the fact
that the field of health services illustrates,
perhaps better than any other, the paradox of our age,
which is, of course, the enormous gap
between our scientific knowledge and skills
on the one hand, and our organizational
and financial arrangements to apply them
to the needs of [people],
on the other.

Royal Commission on Health Services, 1964. Vol.1.

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PUBLIC POLICIES FOR HEALTH

The traditional focus of our health care system is the curing of illness and not the prevention of injury and disease. In 1988/89, ninety–seven percent of the Ministry of Health's budget was spent on institutional care, medical services and Pharmacare. Less than 1.5 percent was spent on services such as *health promotion, *public health nursing and inspections, nutrition, and speech and hearing programs. It is time to change this focus. More money should be spent on the prevention of illness or injury and on protecting health. The least amount of money possible should be spent on providing the necessary high quality curative services.

Enabling people
to make their
own health care decisions
is indeed healthy public policy.
PRO-012

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We've reached a state in Canada where medical bills don't make people poor. We haven't reached the state where poverty doesn't make people sick.
IND-073

Public policies for health are not new; they have been a part of social programs for more than a century. In the past they tended to deal with subjects such as immunization and sanitation. Today, the issues are often the natural environment and the nature and organization of work.

There are four basic elements which distinguish *public policies for health* from other public policies.

- They focus on the link between an individual's health and the social and physical environment.
- They involve many different institutions, businesses, organizations, formal and informal community networks, ministries and levels of government.
- They use experts from many different disciplines, not just the health sciences.
- They involve the community in developing and implementing policies to support health.

Public policies for health also encourage government to be accountable for the effect of its initiatives on the health of the community it serves.

*Health and *Health Status*

It is necessary to distinguish between health and the things which influence health. Although the definitions of health attributed to the European Regional Office of the World Health Organization and the Ottawa Charter for Health Promotion are very broad in scope, health status is easier to identify and more meaningful to measure if the things that influence health are removed from these definitions. Therefore, for the purposes of this report, the commission has defined ***health*** as ***a state of physical, mental and social well-being.***

This definition does not mean that only the able-bodied can be healthy. Many people with physical or mental disabilities are healthy and enjoy productive and creative lives.

While a person's decision to smoke or drink and drive affects their health status, focusing solely on individual responsibility runs the risk of blaming the victim and ignoring the influence of surroundings. Staying healthy and acting responsibly are important, but individual health is also linked to the social and physical environment, to the way our society operates.

Poverty, for example, is intimately associated with poor health. More than four years' difference in life expectancy exists between the lowest and highest income levels in Canada, and more than 11 years' difference in disability-free life expectancy. Other influences include:

- early childhood experiences
- housing
- employment status
- workplace hazards
- environmental pollution
- family and friends.

The Health Care System

According to what the commission has heard, it appears that the relative importance of health care and health promotion to the individual depends on that person's state of health. People in poor health, or who know someone in poor health, believe that more money should be spent on health care. People in good health tend to believe that more money should be spent on health promotion.

The news media and the public's attention often focus on dramatic, life-saving operations on very ill people, creating an expectation that more expenditures for high-tech medicine mean better health. But increased spending for hospitals, equipment or health care will not necessarily improve health status. If British Columbians wish to continue to improve the quality and healthy duration of their lives, they must pay more attention to areas outside the health care field. They must coordinate resources from a number of different branches and levels of government to improve the province's health.

Therefore, the commission recommends that:

1. **all levels of government establish procedures to ensure that existing and proposed programs and legislation promote better health.**

Health Status Indicators

Health status indicators identify and define a specific *health outcome, provide a meaningful description of the nature of a health problem, and measure the effect and magnitude of a policy on health. In fact, the process of establishing health status indicators often provides the answer to the problem by clearly defining its solution.

Many of the indicators employed in the past measured the use of the health care system and not health. Such indicators are difficult to interpret and even more difficult to apply to conclusions about the health of the population. Health status indicators, however, provide a direct measure of health.

In its research, the commission compared the following health status indicators for BC's 21 *health units over a four year period.

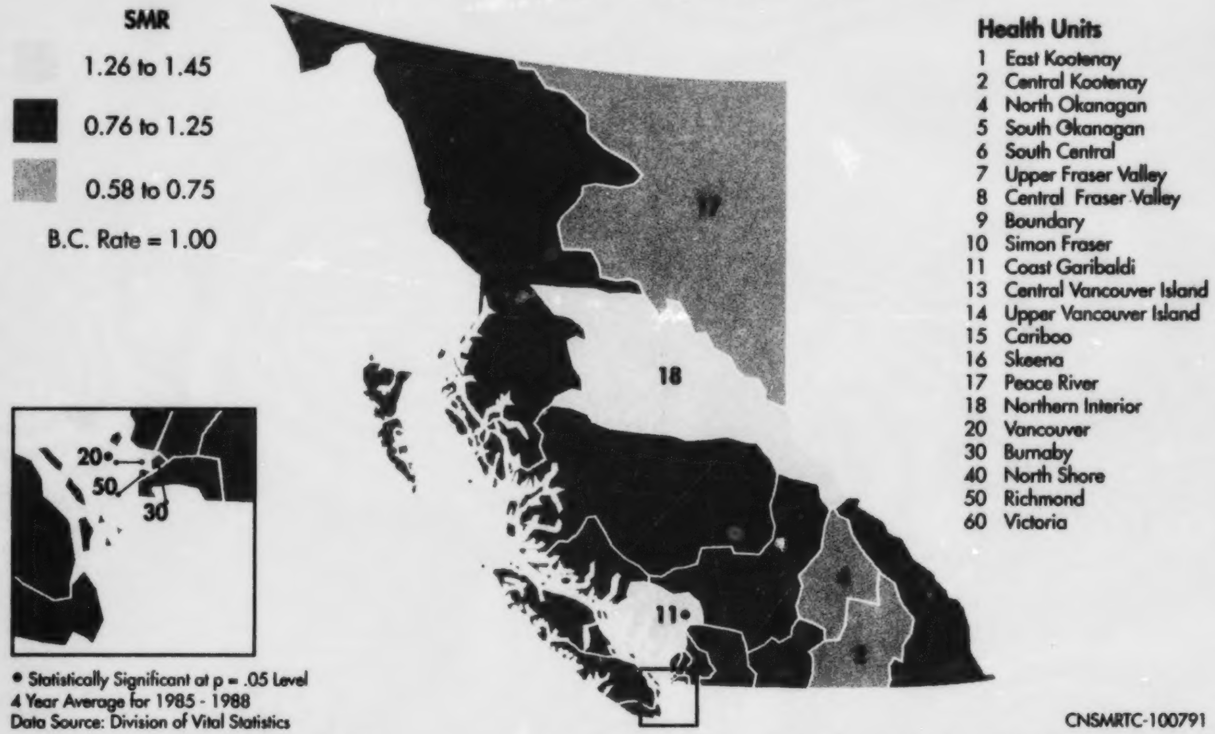
- The infant mortality rate – the number of deaths under one year of age for each 1,000 live births.
- The percentage of low birth weight infants – the number of children with a birth weight below 2,500 grams divided by total births.
- The standardized mortality ratio (SMR) for deaths from accidental causes – the average number of deaths from accidental causes compared with the expected number of deaths from each cause for the province.
- The SMR for deaths from violent causes.
- The SMR for deaths from medically treatable causes.
- The SMR for deaths from alcohol-related causes.

This comparison showed significant differences in health status among British Columbians. For example, living close to a major medical centre does not necessarily decrease the risk of dying from a treatable disease. Higher rates of death from medically treatable causes were found more often in the communities with BC's major medical centres than elsewhere.

There is no one-to-one link between an individual with certain socio-demographic characteristics and a specific health outcome. This means that the type of information available to a researcher may only permit prudent action rather than action based on a more substantial burden of proof. However, certain outcomes may be explained by identifying statistically significant connections between them and certain socio-demographic factors. We used four of these factors in our analysis.

- The proportion of Native Canadians living in an area.
- The average household income.
- The proportion of the population 15 years and older with an education level of grade 9 or less.
- The proportion of single parent families.

BC STANDARDIZED MORTALITY RATIO - TREATABLE CAUSES BY HEALTH UNIT


SMR
1.26 to 1.45
0.76 to 1.25
0.58 to 0.75
B.C. Rate = 1.00
Health Units
1 East Kootenay
2 Central Kootenay
4 North Okanagan
5 South Okanagan
6 South Central
7 Upper Fraser Valley
8 Central Fraser Valley
9 Boundary
10 Simon Fraser
11 Coast Garibaldi
13 Central Vancouver Island
14 Upper Vancouver Island
15 Cariboo
16 Skeena
17 Peace River
18 Northern Interior
20 Vancouver
30 Burnaby
40 North Shore
50 Richmond
60 Victoria
17
18
11•
20•
50
30

• Statistically Significant at p = .05 Level
4 Year Average for 1985 - 1988
Data Source: Division of Vital Statistics

CNSMRTC-100791

Prepared by: Health Economics & Planning Branch, Ministry of Health

Map Source: Planning & Statistics Division, Ministry of Finance & Corporate Relations

This analysis led to the following observations.

- Health units with a higher proportion of Natives in their population are more likely to have a higher infant mortality rate and more deaths due to accidental causes, alcohol-related causes and medically treatable causes than the rest of the province.
- Health units with a higher proportion of people 15 years and older with grade 9 education or less in their population are more likely to have more deaths due to accidental and alcohol-related causes than the rest of the province.
- Health units with a higher proportion of people with low household incomes in their population are more likely to have more deaths from accidental and alcohol-related causes than the rest of the province.

The six health status indicators the commission used were selected because they were fairly easy to work with, and the data were readily available. Other indicators which could be included in a comprehensive set of provincial health status indicators are:

- the number of disability–free years people can expect to have
- the standardized mortality ratio (SMR) for *lifestyle-associated diseases
- the SMR for *preventable diseases
- indicators which are sensitive to the social and economic *determinants of health, for

example, the gap in income between the rich and the poor, or the potential years of life lost because of living in poverty.

The commission thinks that any *health goals established by the province should be based on the provincial health units, or *local health areas, with the best results.

Therefore, the commission recommends that:

2. **the provincial government establish a comprehensive set of health status indicators and use those indicators to help it plan and evaluate public policies for health.**

The Healthy Communities Movement

The commission found many examples of communities directly involved in addressing health problems in their own areas. The healthy communities movement is an excellent example.

Some of the communities involved in the project have received help from the government's Healthy Communities Initiative Fund, but many others still lack the resources necessary to become "healthy". We feel that the costs associated with helping these communities will be offset by the benefits to health arising from citizen participation in and ownership of the solution.

Therefore, the commission recommends that:

3. **all levels of government support the healthy communities movement.**

Safeguards and Assessment

Public policies for health can be difficult to identify and develop, let alone implement, since the priorities of one government department or agency often conflict with the priorities of another. For example, a department promoting logging or mining in an area may disagree with a department that views the same area as a valuable watershed.

To avoid these conflicts, therefore, there needs to be a formal mechanism within government to safeguard the health of individuals, particularly of children and the elderly. Communities should be directly involved in decision-making and in assessing health issues associated with major projects to ensure that the relevant issues are debated in a public forum.

Currently, an assessment of health issues is only carried out when a particular health concern has been identified, or if a major industrial development is to be located near a large population centre. The analysis is then only a secondary part of an environmental impact assessment, conducted largely at the government's discretion. There is no legal requirement that a development's effect on public health be assessed.

> *In BC*
> *the Provincial Government*
> *appears*
> *to be*
> *a little bit confused*
> *in how to reach*
> *the goal of health promotion*
> *in communities.*
> HCP-132

* GLOSSARY

Therefore, the commission recommends that:

4. **all proposed provincial programs or legislation, or substantial changes to existing programs or legislation, be reviewed by the Ministry of Health to identify the possible health effect.**
5. **where an environmental impact analysis is undertaken, it include a study of the potential effects on human health. The Ministry of Health must participate in that analysis.**

A Health Watchdog

The provincial health officer is the senior medical health officer for the province and has the power to take action when the health of the public is, or may be, endangered. Despite this, the officer is often unable to criticize government or its agencies. We think that a more independent health watchdog is needed.

Therefore, the commission recommends that:

6. **the provincial health officer and the medical health officers be encouraged to make public statements relating to issues affecting the public health.**
7. **the provincial health officer file an annual report with the Provincial Health Council on the activities of the office and the activities of all of the medical health officers.**
8. **the Provincial Health Council have the authority to direct the provincial health officer to investigate a public health concern.**

The Application of Public Policies for Health

The commission has identified a number of areas where it feels public policies for health should be applied in BC.

• *Poverty*

Greater wealth is associated with greater health. Yet the Fraser Institute recently reported that those people with higher incomes use more health care resources than those with lower incomes. It appears, therefore, that we may have our spending priorities reversed.

While not all poor people are unhealthy, poorer people, particularly children, are more vulnerable to a variety of ailments. Reforms in welfare, income security, housing, and employment can improve health. These reforms must be used to combat the fundamental causes of poverty. In ***Children and Youth*** we have made a recommendation regarding welfare rates for families with children.

• *Child Development*

*Prenatal and early childhood conditions have a direct effect on lifelong health. Poverty can result in both immediate (disease) and long-term (delayed development) physical and mental health problems for children. Diet supplementation for mothers and young children may reduce the number of people likely to suffer major health problems at birth or later in their lives.

• *Labour Market Policies*

An employer's organizational and management style can have a significant effect on a worker's sense of dignity, self-worth and responsibility. The commission thinks that public policies that encourage workers to feel that their jobs are meaningful, and that allow them to influence decisions in the workplace, will improve the population's health and productivity.

• *Occupational Health*

More work days are lost in BC every year due to industrial injuries and illness than as a result of strikes and lockouts. While the effect of workplace accidents on the economy can be measured in dollars, the consequences for workers and their families go far beyond lost wages.

The national ***Workplace Hazardous Materials Information System*** is an example of a program where cooperation between government, employers and workers has resulted in improved health and safety standards. We think that further gains could be achieved by improving occupational health and safety programs and reforming current legislation.

For example, agricultural workers are not covered by existing legislation despite the fact that they face serious hazards (pesticides, fungicides, herbicides and fertilizers) in their workplace. Farmers might face increased costs if they have to comply with new safety legislation, but we think that well considered public policies could provide farm workers with suitable protection without compromising the financial viability of the farming industry. The United States and many European countries have established comprehensive farm safety programs; BC needs to do the same. The commission understands that draft regulations to protect farm workers are currently before the Workers' Compensation Board.

> ***The provincial experience ranks farming injury rates comparable to sawmills, safer than logging but with a higher claims rate than mining or pulp and paper – all of which industries fall within a regulated occupational safety program. Indeed, there is a significant inequity between the risks in farming and the lack of organized industry safety programs.***
>
> **Occupational Safety and Health in the Agriculture Industry, November, 1988.**

• *Sustainable Development*

A healthy environment is necessary for a healthy life, but this requires more than just a set of pollution standards. Conservation and economic growth are inextricably joined in our society, and public policies directed toward the promotion of one at the expense of the other will not work.

• *Water*

Most people in BC believe that their tap water is glacier fresh. The reality is something very different.

- BC's annual rate of waterborne diseases is consistently higher than the national average. In 1989, BC's rate was 45.3 cases per 100,000 population, compared with a national average of 30.4 cases per 100,000.
- There were 1,582 reported cases of waterborne diseases in BC in 1990. More than 1,200 cases have been reported each year since the mid-1980s. Giardiasis (beaver fever) is the most common waterborne disease.
- The number of "boilwater" advisories has increased dramatically since the mid-1980s. Over 100 such orders were issued by the government in the first three months of this year.
- The government estimates that about 450,000 British Columbians currently face some risk of biological contamination of their water systems.

Industrial and recreational use of watersheds can compromise the quality of drinking water. A lack of safe drinking water not only affects public health, it can adversely affect tourism and economic development. Yet there is no comprehensive legislation in place to ensure that high quality drinking water is provided at a reasonable cost. BC's average water rate is about $11 per 10 cubic metres of water; the Canadian average is just over $15. Although the Ministry of Health should have a predominant role in monitoring and advising on drinking water, neither it nor any other single ministry has been given overall responsibility for addressing this issue.

Therefore, the commission recommends that:

9. all levels of government ensure that safe drinking water is provided at a reasonable cost to every person who is connected to a community water supply system.

• *Motor Vehicle Accidents*

Motor vehicle-related accidents (MVAs) have increased dramatically in recent years, especially among people 18 to 25 years old. Many victims of such accidents are severely injured and require extensive and expensive medical treatment. For example, MVAs cause approximately 150 spinal cord injuries every year in BC. The average age of victims is 19 years. Most are male.

Injuries from MVAs add a major burden to the lives of British Columbians and to the health care system, and it is crucial to focus on their prevention and their lifestyle–related causes. Public policies for health could be used to answer such questions as whether granting a licence to a beer and wine store with quick highway access would be likely to encourage inappropriate alcohol consumption by drivers.

An analysis of accidents, involving the Insurance Corporation of BC, should play a major role in planning the future of the health care system. Driving and substance abuse are addressed more fully in ***Substance Abuse.***

• *Self-Esteem*

Our ability to make choices and to be satisfied with those choices, at work, at home or in our community, is important to our well-being. Our relationships, particularly with our families and friends, provide us with a sense of identity, and a base from which to exercise control over our lives and to influence our health. These and other factors contribute to self-esteem and our sense of responsibility toward others.

A sense of control is fundamental to this commission's vision of health and what the health care system should be. Control may be exercised at a local or community level as different organizations make spending decisions. But it may also be realized at an individual level as people make personal and lifestyle decisions.

We think that more people want to be involved in developing and implementing policies to improve their health. Government can play an important role, but it is the citizens of this province who must take control of the issues which affect their health and the health of their communities.

Illness and Injury Prevention Initiatives

We believe that the following initiatives should be implemented without further consideration.

• *Bicycle Helmets*

Brain injuries can cause epilepsy, intellectual and memory impairment, and personality changes. They can cost $1,000 per person a day to treat and lifetime *extended care costs can be as much as $200,000 a year. Bicycle accidents are the most common cause of head injuries in children and far too many cyclists die or are left seriously impaired because they do not wear bicycle safety helmets.

The BC Medical Association (BCMA) estimates that bicycle safety helmets can reduce the risk of head injury by 85 percent and brain injury by 88 percent.

Therefore, the commission recommends that:

10. legislation require that approved bicycle safety helmets be worn by people riding bicycles, regardless of the age of the rider, the type or size of bicycle, or where that bicycle is used.

Bicycle safety helmets are not expensive to buy, especially when compared with the potential suffering and cost of not wearing one.

• *Bicycle Paths*

Over 47,000 bicycle trips are made each weekday in Vancouver. Eighty-five percent of those trips are to or from work or places of education. This means most cycling is done during rush hours. It is not surprising, then, to learn that most bicycle deaths involve motor vehicles.

Therefore, the commission recommends that:

11. all levels of government create more and better bicycle pathways and dedicated bicycle areas on roadways, and make the use of bicycles part of their transportation plans.

• *The Alcohol Limit*

The inappropriate use of alcohol contributes, directly or indirectly, to many injuries and illnesses, consuming lives and valuable resources. Drinking and driving is of particular concern, involving thousands of people in alcohol-related road accidents each year.

The heavier you are, the more alcohol you have to consume to reach a given limit. Men and women metabolize and eliminate alcohol at about the same rate (0.015 grams of ethanol per deciliter of blood per hour), but because women have proportionately more body fat than men, a woman can attain a higher blood alcohol level than a man of the same weight from the same amount of alcohol. One hour after she has consumed 8 oz. of beer, 4 oz. of wine, or 1 oz. of liquor, a 100 lb. (45.45 kilograms) woman of good health would have a theoretical maximum blood alcohol level of about 0.02 grams per deciliter. The level for a 100 lb. man would be somewhat less than that.

At the current blood alcohol limit of 0.08 grams per deciliter, every driver is effectively impaired. But most drivers will be impaired at levels below the current legal limit, and many people will be impaired to some degree at half the current limit.

We think that it would be best if there was a prohibition against consuming *any* amount of alcohol before driving a motor vehicle. But compliance with such a standard would be difficult to enforce. Therefore, we believe that the standard for the upper limit of blood alcohol should be based on a woman of good health who weighs 100 lbs. That woman, and most other people, should experience no significant degree of impairment if they drive one hour after drinking one drink.

Therefore, the commission recommends that:

12. the government
- **a. promote a "one drink rule;"**
- **b. lower the limit for blood alcohol content for motor vehicle operators to a maximum of 0.04 g/dL; and**
- **c. undertake a program to monitor drinking and driving to determine if the limit should be lowered further.**

• *Truck Braking Systems*

Defective or poorly adjusted truck brakes cause injuries and take lives.

In a recent 72-hour road check in BC, 41 percent of the commercial vehicles inspected had defective brakes or improperly adjusted brakes. Although the United States has passed legislation making it mandatory to have braking systems on all of the wheels of a commercial vehicle, Canada lacks a similar law, increasing the threat posed by large vehicles on our highways. Similarly, nowhere in North America are automatic brake adjusters required, although they are relatively inexpensive and have been mandatory in Europe for a number of years.

Therefore, the commission recommends that:

13. a. all commercial vehicles to be licensed to operate in British Columbia have brakes installed on all wheels; and
- **b. commencing July 1, 1992, all licensed commercial vehicles be required to have brakes on all wheels.**

14. when a vehicle has failed a roadside inspection for reasons of brake adjustment
- **a. the owner be barred from owning commercial vehicles not equipped with automatic brake adjusters on all wheels; and**
- **b. the driver be required to requalify for the right to operate a vehicle with air brakes.**

Immunization

Immunization is an effective disease prevention strategy. It can contain costs of health care services by reducing hospital use and physician visits. More importantly, it can reduce the rate of illness and death.

Bio-technology has reduced the cost of vaccines and increased competition among manufacturers, and safer, more effective products are becoming available faster than before. Bio-technology has also produced a variety of vaccines for the same disease, making it necessary to consider more than just price when selecting a product. For example, one vaccine may have potent early immunological effects which then decrease rapidly, while another may require multiple immunizations but last longer. Some vaccines, such as hepatitis B vaccination, can reduce the consequences of acute infections as well as reduce chronic illness.

By reducing the type and severity of side effects, the new vaccines should also increase the acceptability of immunization. Education for health care workers and the general public on the potential benefits, limitations and consequences of different vaccines is, therefore, becoming increasingly important.

• *Licensing and Approval*

Before a vaccine can be used, it must be licensed by the federal government's Bureau of Biologics, then receive provincial approval for bulk purchase, a process which is being delayed by the large number of new vaccines which need to be evaluated. Provincially, the process is further inhibited by:

- an out-dated administrative structure
- the absence of complete information about the products being evaluated (information available to the federal Bureau of Biologics is provided to them by the manufacturer on the grounds that the information will be held in confidence and used only for licensure, not for release to the province)
- a separation between the province's review body, the Communicable Disease Control Policy Committee, the Provincial Epidemiologist, who is responsible for the purchase and distribution of vaccines, and Treasury Board, which approves funding for the purchase of vaccines.

Treasury Board acts independently, withholding funds until it is satisfied it has the information it wants about the cost effectiveness of a vaccine. It does not, however, provide the Provincial Epidemiologist with the money necessary to get the relevant information when a disease is not reportable or information is incomplete. Nor has it supplied money to establish a routine monitoring system.

Guidelines defining the type of information Treasury Board needs do not exist. Explicit criteria and an allocated budget need to be developed for funding new vaccines and for speeding the purchase of new vaccines about to be licensed by the Bureau of Biologics.

Therefore, the commission recommends that:

15. the provincial government
   - **a. develop explicit criteria for the funding and approval of new vaccines; and**
   - **b. allocate funds for the purchase of vaccines nearing licensure by the federal Bureau of Biologics.**

• *Vaccine Research*

The negative side-effects of a vaccine are supposed to be reported to the physician or health unit responsible for administering the vaccine. However, there is a serious problem in under-reporting in the province.

Side effects can occur many days or weeks after vaccination and often are not recognized as being associated with the injection. Follow-up research on side effects is rarely done; what little there is, is usually paid for by the drug companies and deals with problems after they appear.

The provinces currently collaborate to purchase drugs on a bulk basis. They could make these purchases subject to the posting of performance bonds by the manufacturer and to money being made available by the manufacturer for post-licensing surveillance, research and education. These funds would be administered at arm's length from the manufacturer and the post-licensing surveillance would be done on an inter-provincial peer review basis, thereby ensuring timely and high quality research. The BC Health Research Foundation could participate with agencies in other provinces to develop methods of post-marketing surveillance and research, as well as educating the public about immunizations.

Therefore, the commission recommends that:

16. the provincial government

- **a. make it a condition of the purchase of vaccines that a set amount of money be put aside by the vaccine manufacturer to be used for independent research on the potential consequences of using the vaccine; and**
- **b. collaborate with the other provinces to establish a coherent and standardized process to fund post-licensing research.**

• *Recording Vaccinations*

A centralized immunization registry in BC would:

- provide individuals with their immunization history
- identify at-risk individuals in the event of an epidemic
- monitor the level of disease protection that programs achieve
- monitor the level of immunization in different groups in the population
- provide a way to implement an adverse reaction follow-up system
- make it possible for the province to actively foster research on vaccine-preventable diseases.

An effective, publicly funded program for childhood immunizations (diphtheria-tetanus-pertussis, poliomyelitis, measles, mumps and rubella vaccines) already exists in schools. However, in spite of strong evidence of the health benefits for children, their parents and siblings, and the staff of child care centres, there are no requirements for children attending pre-schools or day-cares to be immunized.

The immunization record of each child in the province is stored in a health unit office. The province relies on these records to decide if children are individually and collectively safe during cyclical periods of diseases, but these are generally paper records and are difficult to use for managing immunization programs.

Based on the existing records, current immunization levels are considered satisfactory. In the Lower Mainland, though, lower rates may be found in pre-school children and children in their first year due to:

- high in-migration
- reliance on private medical practice rather than public health
- a lack of immunizations among certain ethnic and social groups.

Alberta and Saskatchewan maintain high rates of immunization among children by providing immunizations solely through public health clinics. Immunization rates are also high in rural BC, where public health units are the primary source for childhood immunizations. Where the public health clinic is inconvenient, or for medical reasons such as the presence of a disease, it is appropriate that physicians are involved in immunization.

New Brunswick, Ontario and a number of American states have made immunization against childhood diseases mandatory for all children entering school. Some US states require that children be immunized before they attend pre-school. A similar approach has been rejected by BC. But if the province does not wish to make immunizations compulsory, it should, as a minimum, make a student's immunization history a prerequisite to attending school.

Section 9 of the Health Act allows the filing of an affidavit if a parent conscientiously objects to a child being immunized. Parents should continue to have this option, but it should not prevent the school from protecting that student or other students and staff from a communicable disease by prohibiting the unimmunized student from attending classes.

Therefore, the commission recommends that:

17. the province

- **a. encourage the provision of all childhood immunization through public health clinics; and**
- **b. empower the provincial health officer to require proof of appropriate immunization upon entry to and attendance at a school or pre-school.**

• *Immunizing the Public*

Immunization includes more than just the purchase and delivery of vaccines. It also involves marketing to convince adults and adolescents of the need to receive and maintain immunological protection. And it includes educating health care workers.

The *public* component of public health is rapidly being lost to the professional preference for a client centred approach, and most immunization programs rely on face to face information sessions with the consumer. Public information campaigns are seldom used now, largely due to the adoption of the American system of care and its focus on individual rather than on public good.

But, because of the variety of vaccines available and different cultural attitudes and knowledge about immunization, it is becoming more difficult to maintain high levels of immunological protection. Although we do not know the best way to inform the public about the costs, benefits and limitations of immunizations, we do believe that it is necessary for public health to recapture a population-based approach to health.

Therefore, the commission recommends that:

18. a. the province ensure that vaccine manufacturers provide funds to support health education research and health education materials, including materials appropriate to different language and ethnic groups; and

b. the British Columbia Health Care Research Foundation use these funds in part to evaluate the effectiveness of health education programs.

• *Universal Insurance*

There is no doubt that efforts to protect society can result in harm to some people. The alternative, however, is not acceptable. The recent outbreak of measles in Ontario and Quebec reaffirms what public health advocates have known since the 19th century: the risks associated with immunization are less than those associated with disease.

Nevertheless, the increase in vaccine liability suits in the United States during the 1970s and 1980s has resulted in a decrease in the availability of vaccines and in the number of companies developing them. This has meant that the cost of vaccines has increased, some states have drawn back from mass immunization programs, and there has been an increase in childhood communicable diseases. As a result, the US government moved to provide insurance.

The Prichard Report on medical/legal liability in the health care system in Canada recommended a no-fault compensation scheme for individuals suffering from avoidable health care injuries, such as vaccine injuries. We agree with the thrust of the *Report.*

Therefore, the commission recommends that:

19. the province develop a no-fault compensation plan that would cover all vaccine-associated injuries.

Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) are a group of infections and infestations that are primarily transmitted through intimate sexual contact. They are characterized by:

- a local genital lesion or abnormality such as an ulcer
- vaginal or cervical inflammation
- male urethral inflammation
- parasitic irritation and genital rash.

Hepatitis B virus and AIDS are STDs that cause systemic infection and are not associated with a local genital lesion. Gonorrhea, syphilis, hepatitis B and AIDS are all legally reportable to health officials by physicians and laboratories. Positive lab tests for chlamydia and herpes are reportable by laboratories only.

Since all STDs may be transmitted in a similar fashion, efforts to control and prevent them are generic. When people change their sexual behaviour to reduce the risk of one STD, for example, by using latex condoms to prevent HIV transmission, they prevent many other STDs. Education should therefore focus on general measures to reduce risk rather than on specific STDs.

Public health departments play an important role in the control and treatment of STDs. Contact tracing, partner notification, prevention and education are important parts of control and prevention which are discussed in ***HIV and AIDS.*** The participation of physicians in the reporting of STDs is also critically important.

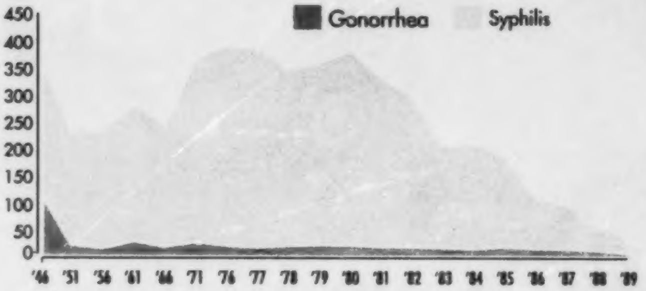
Reporting varies widely throughout the province, as does the competence with which this responsibility is carried out. Furthermore, the relative priority of STD programs in a health unit depends on the resources available in that unit. The fact that there is no program standard for the province means that in some regions the level of STD services is minimal.

Therefore, the commission recommends that:

20. the Ministry of Health, through the Sexually Transmitted Disease Control Branch
  - **a. develop and implement a province-wide public education program on sexually transmitted diseases. This program to include the following basic elements:**
    - **i. routes of transmission and methods of prevention, including the effective use of latex condoms;**
    - **ii. repeated and reinforced public messages;**
    - **iii. periodic evaluation of the results of the education program; and**
    - **iv. appropriate program modifications to increase behaviour change and reduce all STDs in the province.**
  - **b. develop a surveillance system for non-reportable STDs, including strategies such as a sentinel physicians' network, expanded screening and improved STD laboratory reporting.**

21. the role and responsibilities of all public health departments in the control and treatment of STDs be expanded and clearly defined.

22. medications for the treatment and *prophylaxis of all STDs be made available, free of charge, through the Provincial Pharmacy, Centre for Disease Control.

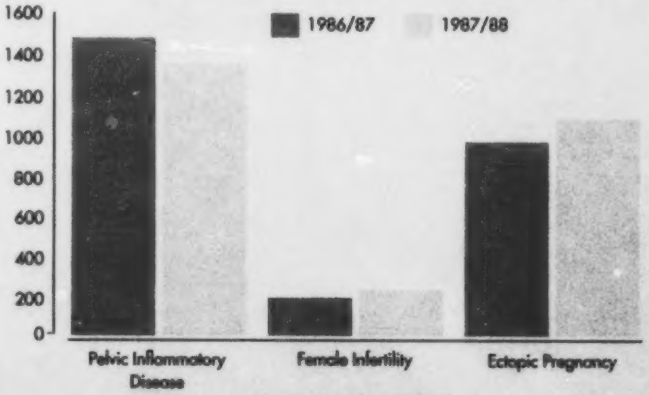


NEW NOTIFICATIONS OF VENEREAL INFECTION
and rates per 100,000 Population, BC

Source: STD Control Div - 1983-88 A/R

• *Gonorrhea and Syphilis*

Approximately half of all gonorrhea cases and 80 percent of syphilis cases are reported by physicians. Gonorrhea and syphilis have decreased by about 75 percent from 1980 to 1989 as a result of the fear surrounding herpes in the early 1980s and AIDS in the latter part of the decade. However, some areas have reported a rebound in cases during 1990 and 1991.



PELVIC INFLAMMATORY DISEASE,
FEMALE INFERTILITY & ECTOPIC PREGNANCIES

Source: STD Control Div - 1983-88 A/R

* GLOSSARY

• *Chlamydia trachomatis*

Chlamydia has a propensity to cause pelvic inflammatory disease (PID), often subsequent to asymptomatic cervical infection. PID usually results in hospitalization and the use of intravenous antibiotics in the short term; the subsequent tubal scarring is the primary cause of infertility and ectopic pregnancy in BC. Ectopic pregnancy in Canada in general is increasing.

> *...when my daughter*
> *was dying,*
> *I held her*
> *and her tears*
> *were infected.*
> *I could have*
> *had hepatitis*
> *from a tear...*
> *God...*
> *to watch my daughter,*
> *my beautiful child die,*
> *and her body*
> *all swollen,*
> *and when I left*
> *for work at five,*
> *and when I*
> *came back at two,*
> *she didn't even*
> *know me.*
> *IND-319*

The commission has been told that diagnostic testing for chlamydia has improved in the past several years. We have also been told that an automated test is readily accessible to physicians and is considered cost effective for a primary case-finding program. National protocols for the diagnosis and treatment of this disease are currently being revised.

Therefore, the commission recommends that:

23. national protocols for the diagnosis and treatment of chlamydia be followed.

• *Venereal Warts*

Venereal warts are caused by human papillomavirus (HPV). It is difficult to identify HPV infection as there are no practical laboratory tests for it. Fortunately, HPV infection of the cervix is often detected in a PAP smear.

- HPV infection is probably lifelong.
- Drugs to treat other STDs have no effect on HPV.
- Treating the warts is unsatisfactory.
- HPV can be transmitted by skin contact which may occur even when condoms are used.

HPV is important not only because of its prevalence in the population, but also because it is closely associated with cervical cancer.

Therefore, the commission recommends that:

24. physicians test for HPV during routine PAP smears and advise each woman whether the test is positive or negative.

25. the British Columbia Health Research Foundation encourage research on HPV to determine prevalence, incidence, treatment and prevention methods.

• *Hepatitis B*

Hepatitis B virus (HBV) infection is transmitted sexually, by contaminated blood and needles and perinatally. It spreads particularly easily within households. Reports of HBV infection have been steadily increasing in BC in the last five years. There were almost 1,000 new cases reported in 1990 alone and sexual transmission probably accounts for one-third of all of these cases.

The groups most at risk for hepatitis B are similar to the groups most at risk for AIDS: intravenous drug users, homosexual and bisexual males, heterosexual people with numerous partners, sexual partners of these groups and babies born to parents from these groups. HBV is, however, easily diagnosed, both clinically and by blood tests, and, unique among STDs, it is preventable by vaccination.

The current price to a person in BC for a hepatitis B vaccination is approximately $100. A Korean vaccine, produced under patent to the New York Blood Group, is currently priced at less than a dollar.

The commission has heard evidence that limits have been placed on testing people for HBV by the BC Provincial Laboratory. This has been done under the misunderstanding that individuals without an MSP number are not covered for this service. We would like to remind the laboratory that a Medical Services Plan number is not necessary to receive service from a provincial laboratory or hospital.

The American Academy of Paediatrics is currently drafting recommendations which call for the universal immunization of infants against hepatitis B. While the benefits of a universal infant immunization program would not be realized within the next 10 years, an investment now will have major economic and social benefits in the future. In order to control HBV, there needs to be public education, accessible testing and an expanded program of vaccination.

Therefore, the commission recommends that:

26. the province immediately establish a province-wide program to immunize infants, children, high risk groups and new immigrants against hepatitis B.

THE BEST CARE

> *No one, I think, who brings ordinary powers*
> *of observation to bear on the sick and maimed*
> *can fail to observe a remarkable difference...*
> *in their duration and in their termination*
> *in different hospitals...*
> *The elements which really give information...*
> *are those which show the proportion of sick*
> *restored to health, and the average time*
> *which has been required for this object.*
> *The proportion of recoveries, the proportion of deaths,*
> *and the average time in hospital must all be*
> *taken into account...as well as the character*
> *of the cases and the proportion of different ages.*
> *Hospital mortality statistics give*
> *little information on the point.*
> Florence Nightingale, Notes on Hospitals;
> Being Two Papers Read Before the National Association for the
> Promotion of Social Science in Liverpool, in October, 1858

Florence Nightingale's statement is still partially true today. Hospitals *do* keep information on the age of the patients they treat, the number of days they stay in hospital and their condition throughout their stay. But there is no standard recording of the state of patients upon admission and discharge, or of patients' health after they leave hospital unless they are readmitted. This makes it difficult to evaluate the long-term effect of hospital care.

This lack of information is further complicated by the fact that there is little or no information on the effect of care provided outside of hospitals. This makes it difficult for the Ministry of Health to analyze the overall effect of health care on patients and the population.

Thirty two percent of provincial tax revenues are spent on health care in this province. The commission believes that British Columbians should know much more than they now know about whether or not they are receiving the best care possible for their money. Taxpayers must demand accountability for tax dollars.

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Collecting Information

The commission supports the Ministry of Health in its current initiatives to develop the client register and the record linkage system. These will help it track a patient's use of services throughout the health care system. To accurately measure and evaluate the outcome of health care, we need to know what procedures are carried out on patients and the results of that care.

We also support the ministry's introduction of the Care Card, the unique patient identification number and the establishment of the Program Monitoring and Education Branch of the Medical Services Commission. This branch will evaluate the *health outcomes of the patients of individual physicians and groups of physicians in each region of the province.

But the ministry must go further and collecting comprehensive information is the first step.

There are many examples where information is collected in one part of the system, sent off in a report, or put in a computer never to be shared again. Good management information about utilization of the system and patterns of practice within the system needs to be shared and shared more easily.
PRO-055

The information currently collected on hospitals and physician care often only describes what is done to patients and not the results. Very little information is collected on the care provided in *long term care facilities, at home, or through community programs.

To be useful, information must:

- be as simple as possible to collect, using standardized forms
- be stored centrally
- be of practical use to providers and managers
- allow a patient to be followed through the health care system
- allow measurement of the effect of health care services
- allow cost comparisons for different treatments
- allow for the measurement of the population's health.

Health care workers and managers are the people who will have to solve the problems identified by the data that are collected. Therefore, along with members of the Ministry of Health, they must be involved in deciding what information is needed to ensure that it is useful. Health care researchers must also be involved to ensure that the data collected are sound. Too often, information is collected purely for the sake of collecting information.

Therefore, the commission recommends that:

1. **the Ministry of Health**
   a. **determine and collect the health information needed by the province; and**
   b. **stop collecting information which is not used.**
2. **the provincial and federal ministries of health**
   a. **agree on a consistent set of data to be collected; and**
   b. **implement a periodic health survey to provide information on *health status.**

The commission supports the National Task Force on Health Information in its recommendations to coordinate provincial and national health information.

Assessment, Assurance, Review and Management

Quality assessment and assurance and utilization review and management focus on aspects of health care 'outcomes'. They are new words to describe measurements which include old activities. They are closely related to each other and are dependent on each other for success. To ensure that the health care system is doing the most good, the province must use these activities in collecting and analyzing information, and in allocating resources effectively.

- **Quality Assessment* compares what is done to a patient receiving a service in a health care facility with what should be done to provide the most beneficial care to the patient.
- **Quality Assurance* reduces the difference between what happens to a patient receiving a service in a health care facility and what should happen to provide the most beneficial care to the patient.
- **Utilization Review* compares what is done to a patient receiving a service in a health care facility with what should be done to provide the most beneficial care to the patient at the least expense.
- **Utilization Management* reduces the amount of resources used in providing quality care to a patient receiving a service in a health care facility.

These activities are usually grouped under the general heading of Quality Assurance and Utilization Management.

If a procedure is found to have *no effect* or a *negative* effect upon patients, both quality assurance and utilization management would lead to the procedure being stopped.

The central question for those interested in developing quality assurance programs is whether or not there is any evidence that programs which link measurement with action in order to improve care can be successful. Although there is not a large body of research on this topic, there is strong evidence that carefully designed programs can improve the quality of care in both acute and long term care institutions. It is difficult to implement quality assurance and utilization management at the technical level, but the tools are available.

Quality assurance requires the measurement of three components:

- structure - the properties of the setting in which care is provided, including physical resources, human resources, and organizational structure
- process - what is done to the patient
- outcomes - the results of the care provided on the physical and mental well being of the patient.

Virtually all *acute care hospitals in BC have developed the organizational structure for quality assurance programs, but this structure is much less common in the province's long term care facilities. Most of the current activities are directed at ensuring appropriate safety levels and acceptable standards for the delivery of care. Very little emphasis is placed on appropriate outcomes.

As with quality assurance, there has been very little systematic evaluation of utilization management programs in Canada. What has been done suggests that such programs can produce positive results.

An evaluation of the overall effect of comprehensive utilization management programs in the United States indicated some success, although an evaluation of specific interventions, such as second opinion programs, indicated that they have not been as positive.

The tools for utilization review may be classified according to the timing of the assessment. The comparison of standards can occur:

- before treatment begins – prospective review
- during treatment – concurrent review
- after discharge – retrospective review.

Each of these approaches has its advantages, disadvantages and challenges.

* GLOSSARY

• *Legislative and Legal Issues*

All health care facilities in the province are subject to provincial legislation. Each is also governed by the by-laws of that facility and is subject to responsibilities established by the courts, primarily in the area of negligence law.

A good legal framework is essential if quality assurance and utilization management initiatives are to be successful. However, quality assurance and utilization management are not dealt with in a systematic way in the legislation governing health care facilities. This is by no means peculiar to BC, although some provinces have more appropriate legislation. Alberta, for example, requires all institutions above a certain size to have a utilization management committee with specific responsibilities.

• *Barriers to Progress*

Although the greatest barrier to implementing quality assurance and utilization management programs is the complexity of the task, the most important challenge is the lack of commitment and leadership. There are a large number of groups interested in the performance of the health care system, and it appears that they agree upon the need to assess and improve the performance of the system. They do not agree, however, on how to measure quality or how to change the way patients and providers use the system.

The history of the Canadian health care system shows that the provincial government has a mandate to provide leadership, but this does not necessarily mean that it needs to exercise direct control. In some cases it may be enough for the government to provide a general direction to health care groups. In other situations, providing leadership may mean support, either financial or organizational. What is most important, though, is that the government require that quality assurance and utilization management programs be developed, implemented and evaluated.

To provide this leadership, the government should establish a provincial body to support quality assurance and utilization management.

Because the definition of technology includes all medical procedures and services, it is difficult to draw a clear distinction between the functions of a body for quality assurance and utilization management and those of the present BC Office of Health Technology Assessment (BCOHTA).

BCOHTA opened on December 1, 1990, with two years of funding from the provincial government. It promotes and supports the use of assessment research in policy and planning activities at the government level, and in policy, acquisition, and use decisions at the clinical level. Its specific activities are to:

- select technologies to be reviewed in cooperation with the Ministry of Health and distribute quarterly summary papers of the literature reviewed on each technology
- provide assistance to researchers developing research proposals addressing gaps in technology assessment
- conduct research to evaluate methods of influencing decision making
- provide bursary assistance to graduate students pursuing research in technology assessment
- coordinate an annual development conference on selected technologies
- liaise with experts in related areas including law, ethics, epidemiology, and statistics.

BCOHTA is supported by an Advisory Committee, appointed by the minister of health, and a Steering Committee, comprised of people at the Centre for Health Services and Policy Research.

The Advisory Committee of that office already includes representatives from a number of groups in the health care system, including representatives of the College of Physicians and Surgeons, the BCMA, the Registered Nurses Association of BC (RNABC), the BC Health Association, the Science Council, the Ministry of Advanced Education, Training and Technology, the BC Institute of Technology, and the Ministry of Health.

Therefore, the commission recommends that:

3. the provincial government
   a. expand the mandate of the BC Office of Health Technology Assessment to include quality assurance and utilization management activities;
   b. change the name of the BC Office of Health Technology Assessment to the BC Office of Health Care Evaluation; and
   c. ensure that the office have an Advisory Committee which includes representatives of the public and community health organizations.

4. the BC Office of Health Care Evaluation report to the deputy minister of health.

5. the Provincial Health Council have access to any information or research of the BC Office of Health Care Evaluation.

The expanded role of the Evaluation Office would be to:

- collect and analyze information on the use of health care services
- compare outcomes associated with the use of health care services
- coordinate quality assurance activities among the various health care governing bodies and associations
- coordinate quality assurance and utilization management activities
- disseminate research and program information to health professions and health care institutions
- coordinate the province's participation in inter-provincial and international efforts to improve quality assurance and utilization management
- evaluate quality assurance and utilization management initiatives
- collect data to assist in evaluating the success of initiatives
- develop recommendations or incentives to improve quality assurance and utilization management
- coordinate practice guidelines for the application and use of technologies.

The development of practice guidelines (protocols) is an important responsibility of the Evaluation Office. Physicians frequently told the commission that certain procedures or diagnostic tests were ordered simply because of the fear of being sued. We think that the number of inappropriate procedures or tests could be reduced with the use of protocols. Protocols would be particularly helpful to a physician who thought a procedure not necessary except as a defense against a malpractice suit. In other jurisdictions where protocols have been developed, the courts have used them as a guide to proper practice and therefore not found liability where the physician followed the protocol.

You order a certain test, because that's the thing to do; the textbook says so.
HOS-146

Therefore, the commission recommends that:

6. the Medical Services Plan not pay for tests or other medical procedures that fall outside the relevant protocols except when the physician explains in writing the reason a particular case warrants being treated as an exception.

The evaluation office cannot be responsible for ensuring that health care workers provide appropriate care. This is the responsibility of the Ministry of Health and the professional colleges. The deputy minister of health would have the responsibility to ensure that the information provided through the office is used to ensure cost effective spending on care, and the Operational Review Branch is the most appropriate body to help the deputy minister. Unless the deputy minister fulfills the obligation to develop the funding and policy changes necessary to assure appropriate care, the collection and analysis of data will have been a waste of resources.

To further demonstrate its commitment to the principles of quality assurance and utilization management, the provincial government should incorporate these principles into legislation. This legislation should provide guidance without preventing innovation and flexibility. It should provide principles rather than processes and educate the board, management and staff of facilities on the functions they are expected to perform.

All health care facilities in the province should review their by-laws relating to quality assurance and utilization management. To help these reviews, the ministry should work with other interested groups in developing prototype by-laws, appropriate to the varying size and activities of different health facilities.

Therefore, the commission recommends that:

7. all facilities, programs and professions providing health care be required by statute to conduct quality assurance and utilization management activities incorporating the principles of doing the right thing and doing it right.

All facilities above a certain size should be required to have both a quality assurance and a utilization management committee, which includes members of the board of trustees. All facilities, regardless of size, should be required to assign the responsibility for overseeing quality assurance and utilization management functions to one or more individuals or committees operating within the facility. Responsibility for these functions should be specifically set out in the facility's by-laws. They should be integrated with the review activities of the medical staff.

The Ministry of Health should also require that health care programs include quality assurance and utilization management activities.

• *Hospital Privileges*

It is clear from legislation and case law that hospital privileges are just that, privileges and not rights. But, the current process for granting or withdrawing hospital privileges — a central issue in the development of quality assurance and utilization management programs in institutions — is unsatisfactory. There needs to be a process that is fair and equitable to institutions, patients and physicians and gives hospitals and physicians a clear understanding of the basis on which privileges are granted or revoked. All parties need to know:

- the criteria to be used in considering an application
- the process to be followed
- the time limits
- the need for a hearing
- the elements of a hearing
- the right to receive reasons
- the appeal mechanisms
- the time limits for various stages.

The decision to grant privileges is based on more than just the basic competence of the physician. The "whole person" is looked at, as well as the needs of the hospital and the community. Two different sections of the Hospital Act address various facets of granting privileges, but the specific criteria for considering an applicant are not set out.

The Act gives the medical staff of a hospital the primary responsibility for recommending that a physician receive privileges. The Board of Trustees makes the final decision and unsuccessful applicants may appeal the decision to the Medical Appeal Board.

In granting privileges, a hospital may:

- consider the character and personality of the physician. If the applicant is dishonest or disruptive, then privileges may not be granted or renewed.
- require a skill level higher than that for the province in general and refuse privileges to those who do not meet that standard.
- consider whether an applicant physician possesses skills that will meet a need within the hospital or community, provided this need is based on objective criteria and each applicant is considered on merit.
- limit privileges to those physicians who live within a certain distance of the facility.

The board should also consider:

- the effect a new physician may have on the use of the facility (services and other hospital resources).
- the effect of a change in the volume of services on the quality of care.
- the commitment of the applicant to abide by the by-laws, policies and procedures of the facility.

Once a physician obtains privileges, the review of these privileges is not as comprehensive as it should be. It is impossible for hospitals to assess the outcomes of all the patients seen by each member of its medical staff, but hospitals need to conduct a regular detailed review of all their physicians. The board of trustees should revoke the privileges of any physician who does not meet the hospital's standards of care.

Therefore, the commission recommends that:

8. a board of trustees

   a. have a clearly written policy covering the granting, suspending or revoking of the privilege to use a particular facility;

   b. initially not grant privileges for more than one year, and, thereafter, for not more than ten years; and

   c. never grant privileges without a complete review.

Hospital privileges for physicians are privileges, they are not rights.
EDU-027

A hospital has a responsibility to the community to help physicians who do not have hospital privileges to maintain their level of competence. There is benefit to everyone in the community if physicians are allowed to share their knowledge with members of the medical staff.

A board of trustees may also find that the skills or expertise of a particular physician fit specific needs and they should be able to grant qualified privileges permitting physicians to provide specific services.

Therefore, the commission recommends that:

9. physicians who do not have privileges to admit patients or write orders may be granted privileges to participate in continuing education programs.

10. narrowly defined privileges may be granted where appropriate.

Dealing with complaints and discipline is a traditional activity of professional governing bodies. By their nature, however, these activities analyze actions after a patient or health care worker has had cause to complain. These activities are also quite distinct from continuing competence programs.

And all three are different from utilization management activities, which would seek to ensure that professionals consider the benefits and costs in selecting the best care for their patients.

None of the acts governing BC's health care workers has a comprehensive set of provisions to establish and enforce continuing competence programs. However, the commission strongly supports the concept of each professional governing body having a committee with a defined mandate to ensure continuing competence. This would require regulations that remove the legal impediments to such practices as routine audits of practitioner records. The responsibilities of colleges and professionals are more fully discussed in ***Governance of the Health Care Professions.***

Therefore, the commission recommends that:

11. governing bodies of all health professions be required to have a continuing competence committee.

Implementing quality assurance and utilization management programs will identify health care workers who do not practice in accordance with prescribed standards. Unless the severity of the incompetence warrants otherwise, the board of trustees or its equivalent should cooperate with the appropriate college in trying to improve the competence of the provider. In cases of severe incompetence, the final recourse of the board must be to remove privileges or dissolve contracts.

Therefore, the commission recommends that:

12. the governing bodies of health professions be required to respond to enquiries from the governing bodies of health care facilities and programs.

Ultimately, quality assurance and utilization management involves changing behaviours and the government's major role may be to help:

- develop clear and accepted standards for appropriate behaviour

- recognize that there is a problem with certain behaviour
- develop an effective mechanism for bringing behaviour in line with standards.

If behaviour does not change, then the government may have to take more direct action.

For example, research has shown that Canada's high rate of caesarean sections is driven, in part, by the use of repeat sections, even though the Panel of National Consensus Conference has reviewed their use and concluded that physicians should recommend vaginal deliveries to the majority of women who have had previous caesarean sections. The Society of Obstetricians and Gynaecologists of Canada has endorsed the report and recent research has identified effective ways of bringing current medical practice into line with the Panel's recommendations. However, practices are not changing and, therefore, there is no legitimate reason why the government should not act now to reduce the caesarean section rate by enforcing province-wide standards for care, or by increasing the use of midwives as described in ***Health Care Personnel***.

• *The Role of the Medical Services Commission*

The Medical Services Commission (MSC) could play an important part in improving physicians' patterns of practice. The Commission sits with the BCMA, the BC College of Physicians and Surgeons, and members of the public on a Patterns of Practice Committee which addresses physician billing practices that fall well beyond standard billing practices.

While we commend this initiative, we believe that the Commission is the appropriate body, in cooperation with the colleges, to monitor the quality of care provided by physicians who bill MSP. MSC has taken steps in this direction by establishing the Program Monitoring and Education Branch, but it should go further. The legislation under which MSC operates should be carefully reviewed and brought up-to-date.

Therefore, the commission recommends that:

13. the Medical Services Commission

a. monitor practitioner billing practices and conduct practice audits for the purpose of identifying mistakes, misbillings, incompetence, misconduct or inappropriate practice; and

b. report to the appropriate college when it has reason to believe that a practitioner may not be competent or may be engaging in inappropriate conduct or practice.

• *Funding*

The provincial government has a direct influence on the health care system through its role as the major source of funding. Yet there are disincentives for the appropriate use of services inherent in the existing *fee-for-service schedule and these need to be corrected. This does not mean that the entire fee-for-service system should be abandoned, rather, as recommended in ***Health Care Personnel***, it should be reviewed and modified to make it more supportive of quality assurance and utilization management goals.

* GLOSSARY

Traditionally, quality assurance and utilization management activities have focused on individual practitioners and individual institutions. The difficulty with this approach is that many of the problems with care are not attributable to individual providers or institutions, or to deliberate misbehaviour. Inappropriate care often results from the decisions of professionally competent and conscientious people acting in what they believe to be a responsible manner.

Inappropriate use which is standard for an institution will not be recognized by the practitioners as inappropriate. The solution lies in province-wide standards, collectively developed but individually applied, and in the application of general financial and structural interventions, as described in ***Hospitals***.

A recent report submitted to the Minnesota Legislature by the Interagency Board for Quality Assurance recommended a Quality Incentive Program (QIP) for nursing homes. The objectives of QIP are to measure the quality of care provided in nursing homes and to provide recognition and financial incentives to the facilities based on these measurements. QIP focuses on actual versus expected outcomes for individual patients to assess the quality of care.

Our own survey of institutions in BC indicated that the structures needed for quality assurance programs are not well developed in long term care facilities, despite the fact that the provincial government has taken a central role in setting standards and guidelines for these facilities. And although the stage may now be set for the development of utilization management programs, many hospitals feel that they do not have the financial and human resources necessary to cover the large start-up costs and significant operating costs of these programs. Implementing such programs may be a formidable challenge, particularly for small institutions. Staff implications alone are substantial, not only involving the hiring of specialized personnel, but also involving changes in the work load of existing staff. Data must be collected, coded, entered and processed to generate meaningful reports on resource use. And once an inappropriate use has been identified, strategies and programs must be developed to address the problem.

The provincial government has already developed a program to introduce hospitals to the principles of utilization management. This initiative could be expanded to include a centrally located staff that provides a uniform system of utilization review (data collection, review, and variance identification) to all facilities. This standardized format would help ensure that comparable data is gathered from each institution. Ministry of Health staff could also help in identifying and choosing a way to modify behaviour in a particular institution.

Therefore, the commission recommends that:

14. the Ministry of Health help facilities implement and conduct utilization management programs.

Technology Assessment

Technology assessment is closely related to utilization review. It measures the benefit to the patient, the resources used and the safety, efficacy, feasibility, cost effectiveness, and socio-economic and ethical consequences of a technology. Technology not only refers to medical devices but it also includes drugs, equipment, techniques and procedures. Its proper assessment offers a means by which the province can fund health care services with a greater knowledge of the anticipated effect of technology on the quality of care.

Although the province cannot afford the time or money to assess all available technologies (the cost of assessment may actually exceed the cost of the technology in some cases), the assessment of selected technologies is necessary if we are to provide cost-effective care. In the United States, studies on specific medical and surgical procedures have indicated that up to 25 percent are performed for inappropriate reasons. Studies on hospital use indicate that up to 30 percent of hospital days are unnecessary, and a significant percentage of hospital admissions are a result of problems with drug therapy. This underlines the need for the province to take a more active role in deciding if the present use of technology is improving the health of patients.

A number of issues must be addressed before the province begins to assess selected old and new technologies:

- the inadequate coordination of technology assessment
- the lack of information and inadequate access to existing information
- the influence of social and political factors.

• *Inadequate Coordination*

People in the health care system and the public receive information on technology from a number of sources including the federal and provincial governments, universities and technical institutes, individual researchers, health care institutions, professional associations and health care workers, manufacturers and marketers, private insurers, and other national and international bodies. No system exists to evaluate the quality of this information or to coordinate the distribution of results.

- Different organizations conduct technology assessment for different reasons, and their conclusions can vary considerably.
- The economic evaluation of a technology reflects the values of the organizations employing the technology and does not necessarily consider individual patient preferences and values.
- Most technology assessments examine safety and efficacy prior to use in a clinical setting. They do not consider overall costs or cost-effectiveness, or the legal, ethical, and social implications of using a specific technology.
- Assessments are often duplicated which is costly and time consuming.
- Technologies and the use of technologies are constantly evolving, and a large number need to be assessed.
- Most technology purchasers and health care workers do not have the resources or expertise necessary to conduct technology assessment, and some lack the training to evaluate the quality of the information they receive.

The recently opened Canadian Coordinating Office of Health Technology Assessment, together with the provincial technology office, provides a means of improving the current situation by coordinating the distribution of information at the national and provincial levels. The national office opened on January 1, 1991 with joint three year funding from the federal and provincial/territorial governments to aid information exchange. It is primarily an information resource for the ministries of health. The office will not be conducting primary research. Instead, it will coordinate the assessment of health care technologies in accordance with the priorities of the Federal/ Provincial/Territorial Conference of Deputy Ministers of Health. The deputy ministers will choose the technologies to be reviewed.

The Ministry,
in my mind,
is taking
a leadership role
already in establishing
an office
of health technology
assessment,
which is going to,
hopefully,
have a leadership role
in developing
some criteria
for what should
be assessed.
Research Forum.

The national office, which currently has no formal links to facilities or workers, should establish formal relationships with organizations in the United States, technology assessment researchers throughout Canada, the Royal College of Physician and Surgeons of Canada, and the College of Family Physicians of Canada. It should also consider funding primary research in selected areas. The national office may also be the most appropriate organization to identify health care personnel shortages in research areas and provide training to health care workers and managers.

• *Lack of Information*

The province is fortunate in that it presently has a database of all the residents in the province who receive medical care. However, the ability of health care workers, managers and researchers, and the BC Office of Health Care Evaluation to measure the actual versus the expected outcomes associated with specific technologies depends on their ability to get information on health indicators, and to track the health status of patients throughout their lives.

• *The Influence of Social and Political Factors*

Without concrete information on the value of a technology, emotional and political influences will determine its placement and use. In the face of inadequate information, the government will be hesitant to restrict a technology which seems to offer the best care.

The potential of technology assessment to overcome social and political influences could be strengthened through timely and relevant assessments. Promises that a technology will "save money" must not be accepted at face value; there are already too many examples of substitute services that have become additional costs to the system. Subsequent funding for any new service should be based on a clear understanding of the relative effectiveness of the procedure.

For example, lithotripsy – the use of sound waves to fragment gall stones – has become an alternative treatment to removing the gall bladder through surgery. To have ensured that the introduction of this service was cost-effective, the province needed to monitor the overall number of gall bladder surgeries performed before and after the introduction of this technology, assess the costs of both services, and monitor the outcome of patients receiving the services. This did not take place.

The Ministry of Health using the provincial and national technology offices must determine whether selected new technologies have been comprehensively evaluated in other provinces or countries. If an assessment is not complete or is in process, then the national office should determine which province(s) will assess the new technology. There should be no duplication of work.

The Ministry of Health, in accordance with national and provincial priorities, should also fund assessment of technologies in use. As discussed in ***The Management of Health Care Services***, the regional general managers will be held responsible for demonstrating that the purchase and use of selected technologies in their regions effectively meet the health needs of the people within the region.

Therefore, the commission recommends that:

15. the following criteria be used in selecting those programs and services to be evaluated:
  - **a. the number of users;**
  - **b. the cost;**
  - **c. the potential change in quality of life;**
  - **d. the ability to change the service, as a result of study; and**
  - **e. the ability of researchers to produce definitive results.**

Access to Information

The commissioners also heard that health care workers, researchers and members of the public all experience some difficulty in gaining access to information held within the provincial government. The commission agrees with the Provincial Ombudsman's report released in March, 1991, that, with appropriate safeguards for privacy and confidentiality, all residents of the province have a right of access to this information. By information, we mean:

- all reports, studies, assessments, and evaluations written by government staff
- all policies, including those on funding decisions
- all information on the costs, use and outcomes of health care services including hospital reports and budgets.

The onus should be on the government to document its reasons for deciding not to make information available.

There is also some concern about the ability of patients to have access to their medical records. The information in the medical record should be considered to be the property of the patient rather than that of the hospital or the physician. The patient should have access to the medical record and is entitled to a copy of the contents at cost. The provincial government should provide non-private information to any inquiring resident within a reasonable period of time.

Therefore, the commission recommends that:

16. legislation
  - **a. provide for access to information based on the principles and limitations set out in the report of the Ombudsman dated March, 1991; and**
  - **b. clearly state that information in medical records is the property of the patient, who is entitled to a copy of the record at cost.**

17. until such legislation is enacted, the Ministry of Health provide access to information as recommended in the Ombudsman's report.

> *The hiding*
> *of personal*
> *medical records*
> *in doctors' offices*
> *is no longer acceptable in the 1990s.*
> SOC-215

THE MANAGEMENT OF HEALTH CARE SERVICES

A number of *submissions to this commission focus on the management of health care services. They describe the current system of management as insensitive to local and regional questions, inflexible in its programs and policies, and unfair in its distribution of resources. According to these submissions, many British Columbians want greater local participation in identifying health care needs as well as more control of health care resources.

The Ministry of Health is not organized to encourage the people it funds, nor those it serves, to participate in the control of the health care system. While some planning at the local level does take place in BC, there is no designated policy for delegating planning authority to communities. And, while proposals for operating budgets and new services come from hospitals and community agencies, all of the monetary decisions occur in Victoria.

We are asking
for a professionally managed system.
SOC-352

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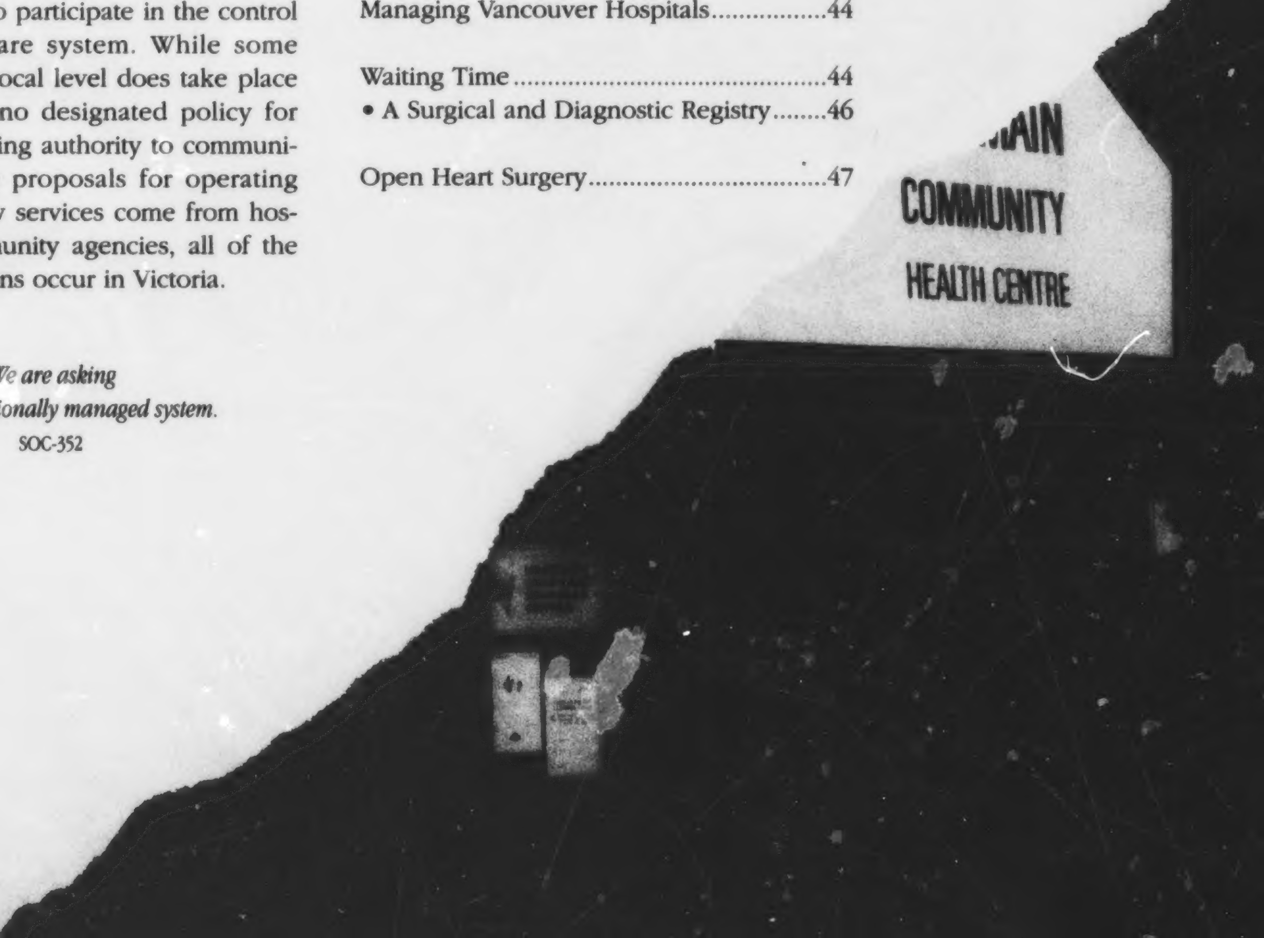

Decision-making powers of the various levels of the system must correspond to the tasks which they have to face. The planning and orientation of the system must be carried out at a level which is close enough to the location of problems to be able to rapidly identify and deal with them, while controlling sufficient resources to allow it to maintain flexibility.

Castonguay-Nepveu Commission, volume 4, tome 2.

Guiding Principles

We believe that decentralizing the control of the health care system will encourage

- public accountability for the management of our health care resources
- cost control through the efficient and effective use of resources
- coordination and integration of professions, institutions and ministries
- services which will serve local needs
- access to services in or as near to an individual's home as is possible.

The Ministry of Health Act

The Ministry of Health Act gives the minister of health broad powers, including power over all health-related matters assigned to the minister under any act or by Cabinet that are not assigned, by law or order-in-council, to another body. The Act names the Ministry of Health as the body to manage and direct health care services on behalf of British Columbians. It allows the minister to

- establish branches or divisions of the ministry
- engage, retain and pay the consultants, experts, or specialists considered necessary to manage the system.

The Act also allows the minister to delegate power to regional and local levels of government. This means that legislation is already in place to change the current structure of the health care system.

The Management Structure

The Ministry of Health is a bureaucracy. In the beginning, responsibility, accountability, and authority for decision-making followed a chain of command from top to bottom (vertical line management). In recent years, however, the ministry has introduced consultants to help managers with certain of their responsibilities.

With the exception of province-wide services such as Pharmacare, the majority of the ministry's services are physically decentralized and locally managed. But the ministry has delegated very little of its authority away from Victoria; it has very few mechanisms for involving interest groups in its operation. In general, staff within program areas help develop budgets, policy, planning, and legislative and research initiatives on behalf of their executive directors and, ultimately, their assistant deputy ministers. Final approvals occur at the assistant deputy, deputy, or ministerial level. Field managers and health care providers then carry out the ministry's decisions.

There are a number of principles that the ministry should adopt to improve its management of the health care system: **decentralization, regional funding envelopes, *matrix organization, and establishing goals and objectives.**

• Centralized Control

As the ministry has grown, it has become more and more difficult for the senior managers within the system to communicate their demands and expectations to the field. To compensate for this, the ministry has centralized decision-making and applied one set of rules to the whole province.

The ministry believes that this management style promotes equality. This commission disagrees.

Decentralization will shift a portion of the decision-making power away from Victoria, substituting several regional authorities for one centralized authority. Decisions which affect the whole health care system will still be made centrally in this decentralized system, but those that depend on regional differences will be made locally.

In this new system, regional general managers will be responsible for the planning and delivery of all health care services within the regions and will report to a senior assistant deputy minister. They will receive their authority from this minister, who, in turn, will be responsible for ensuring that the people in the regions receive the planning and organizational support needed for effective service delivery at the regional level. It is a fundamental principle that all other branches of the ministry exist to support the regions.

This will result in a more efficient and cost-effective system. Ministry staff in Victoria will

- develop overall goals, objectives, legislation, policies and standards
- establish broad action plans
- negotiate the allocation of resources to the regions
- coordinate, monitor, and evaluate the system.

Regional ministry offices will

- involve hospitals, community agencies and other groups in cooperative community planning
- allocate resources
- provide program support regionally and locally.

Successful decentralization depends on the ministry and the regions cooperating in developing *health goals for the province and identifying how to reach these goals. Community-based umbrella groups should involve local agencies in the identification of needs, the coordination of resources and the establishment of service priorities at the community level. Decentralization also depends on a strong assistant deputy minister in Victoria being responsible for the regions.

A *health outcome-oriented management system and a comprehensive information system are also critical. These issues are addressed in ***The Best Care, The Provincial Health Council*** and ***Health Care Personnel***. It will be the responsibility of the ministry and the regions, in partnership, to develop these plans.

Decentralization of authority does not necessarily mean physically transferring all ministry staff from Victoria to the field. Centrally based staff may well be reassigned to the regions, but that is an operational issue for the ministry to decide.

A
provincial health plan
needs
to be developed
that clearly states
the priorities and strategies
used to achieve
integrated health planning.
Regional and community plans
must be aligned
to the
overall provincial plan.
HOS-146

* GLOSSARY

Therefore, the commission recommends that:

1. **the Ministry of Health**
    - a. **retain responsibility for province-wide**
        - i. **goals, priorities, strategic plans, standards, and guidelines;**
        - ii. **management information systems and health care personnel plans;**
        - iii. **budgets, including regional resource allocation across all programs;**
        - iv. ***utilization management, *quality assurance, program monitoring, research and evaluation;**
        - v. **provincial support services;**
        - vi. ***tertiary care services; and**
        - vii. **centrally based services; and**
    - b. **decentralize control for area-specific health services planning and resource allocation;**
    - c. **develop a health services system at the regional and local levels, including**
        - i. **a centrally placed assistant deputy minister, who will assume responsibility for the regions;**
        - ii. **centrally placed Ministry of Health management consulting teams, headed by program executive directors, to assist regional general managers, coordinators, and service providers;**
        - iii. **regionally placed regional general managers, who will assume responsibility for the planning and allocation of health funds within their jurisdiction. Regional general managers will be appointed, under contract, by the minister of health; will be accountable to the minister through the regional assistant deputy minister and the ministry; and will receive a level of pay comparable to that of the CEO of the largest hospital in their region.**
        - iv. **a core complement of regionally placed staff, responsible to the regional general manager; and**
        - v. **regionally placed boards to advise the regional general manager, the boundaries, structure and membership of which will be determined locally; and**
    - d. **give regional general managers responsibility for:**
        - i. **setting regional health goals and plans;**
        - ii. **establishing regional health care personnel plans and assisting organizations in their recruitment and retention efforts;**
        - iii. **preparing regional budgets;**
        - iv. **receiving, reviewing, and approving budget proposals**

from service providers, with the exception of provincial programs;

v. assisting communities in local area planning;

vi. monitoring utilization management and quality assurance;

vii. establishing technical advisory committees; and

viii. encouraging the development of umbrella organizations and the merging of service providers.

Regional funding envelopes will also work to break the ministry down into a number of manageable regional centres, assigning fiscal responsibility to the regional general managers. The envelopes will contain all of the money allocated to health programs in the region: MSP funds, tertiary care funds, and capital and operating dollars for smaller equipment. The only dollars remaining in provincial hands should be those associated with province-wide, ministry-operated programs, such as the BC Centre for Disease Control, the Sexually Transmitted Disease Clinic and capital for facility construction and the purchase of expensive hospital equipment. Tertiary care costs will be recovered by the Ministry from each region for its patients. Regional general managers, working together with the provincial executive director of the Facilities Planning and Construction Division, would plan the allocation of less expensive equipment across regions.

Quebec and Nova Scotia have already proposed to give their regions *global budgets based on population needs, which take into account variations in health risks. In this model, regional general managers can allocate funds between providers, limited only by the provincial health goals, strategic plans, policies, standards and health care personnel plans.

The existing structure of funding and administration of health care funds has not provided integrated planning of service delivery, health education or health promotion at the regional level.
HUT-024

The commission favours a model in which the regional dollars are not preassigned to specific programs. We realize that this will mean a major change for the Ministry of Health and its program-oriented budget process. But changing the current process from one in which funds are distributed from the top to one directed by the community will encourage the movement of services into the community. Agencies will have a chance to enter into joint planning. Health care allocations will evolve out of a regional partnership with an integrated purpose. And public scrutiny of the budget and the allocation process at the regional and local levels will promote informed decisions about the allocation of funds.

For example, in one community we were told about a diabetic outreach clinic which apparently had significantly reduced hospital admissions resulting from difficulties with insulin therapy. This successful program was eventually cut because of budget requirements. Under our proposal, a decision on whether to cut such programs would be made by the regional general manager in consultation with the advisory boards. In this way, the community could conclude that a program should not be cut and reduce some other program instead.

Following on many of the suggestions to the commission, the annual budget cycle could be modified to include forecasts for the ensuing year's budget. This would allow the proposed transfer of money from one program area to another to become part of managed change.

* GLOSSARY

Therefore, the commission recommends that:

2. a. regional budgets be based on a weighted *capitation formula which incorporates local service needs and a broad base of population health risk indicators;

b. regional budgets include all health program dollars, except for programs operated directly by the Ministry of Health, tertiary services, facilities construction and large equipment;

c. the regional budget process be public, allowing an opportunity for consumers and providers to question the budget and advocate changes;

d. regional monies be allocated in ways which encourage the incorporation of utilization management techniques, use the lowest cost appropriate level of care, enable coordination and integration, and increase resource efficiency and effectiveness; and

e. the budget review process become part of a budgeting cycle, so that changes in program direction can be phased in or out.

• *System Fragmentation*

The current management structure of the Ministry of Health has left it without the ability to coordinate programs. Hospital consulting teams, *continuing care regional coordinators and managers, mental health teams, and others all report vertically; the only coordination between the various groups is on an ad hoc or project basis. The introduction of a system of ***matrix organization*** will allow a horizontal structure whereby program executive directors and their respective regional teams work to assist each regional general manager.

This combination of vertical and horizontal lines of authority will encourage teamwork across the present divisions, but it will also make ministry and other staff responsible to two managers. Other jurisdictions have solved this problem by making both the program division or organizational head and the regional general manager jointly responsible for reviewing staff. Regional general managers would have the authority to ensure program integration and coordination of services on behalf of the populations they serve.

Therefore, the commission recommends that:

3. the Ministry of Health

a. organize cross-program regional teams to ensure an integrated and coordinated approach to health services planning, funding and delivery at regional and local levels; and

b. work with the Ministry of Housing and Social Services and other ministries toward the creation of cross-ministerial regional teams.

Vertical line management has also left the ministry with multiple, incongruous planning and delivery boundaries and several governing boards, including hospital, district and union boards of health. This makes planning and funding awkward and confusing to consumers and providers alike and will hamper any attempts to apply a regional network to the delivery of health care in the province.

The ministry needs to adopt one set of planning boundaries, yet allow for flexibility in these boundaries at the provider level. Providers who serve clients in more than one district, or who wish to enter into resource-sharing agreements, should be able to do so.

The Commission has already suggested that tertiary care dollars will, in effect, follow patients, and that the ministry will charge a region for the tertiary care services provided to the people of that region. However, questions about the administration of tertiary care services arise if tertiary care dollars are to become a regional responsibility. The proliferation of these services must be controlled, and the quality of the services proposed or in place in a region closely monitored. Therefore, the management of tertiary care services must be a provincial responsibility. Transfer protocols should be established in addition to a provincial tertiary care plan to guide capital and operating expenses.

Therefore, the commission recommends that:

4. the Ministry of Health and the Ministry of Housing and Social Services enhance system integration and coordination, and ensure data compatibility by establishing common boundaries for all health-related activities.

The commission wishes to see boards amalgamated wherever possible. The move to regionalize control of health care should simplify the system, not introduce an additional layer of bureaucracy. Therefore, we see the office of regional general manager as an extension of the Ministry of Health, receiving support from the ministry's central office through management consulting teams, field managers and staff, as well as assistance from regional and local provider and consumer groups, and regionally placed staff. As such, the ultimate authority over the regional general manager would be senior management in the Ministry of Health.

Is this enough? Other jurisdictions have established regional boards that advise, or have executive authority over, ministry-appointed staff. Since the model the commission is proposing assigns executive authority to a decentralized ministry, any regional or local boards would be advisory in nature.

We believe that there should be a significant degree of self-determination within each community but do not presume to know what is the best way to organize boards for any particular region in the province. We do, however, put forward a number of guiding principles regarding the nature of such boards, while leaving their eventual shape to the people in the regions themselves. These are the people who will decide if they can work together. Imposing a structure upon them will not succeed.

The key point there is to pick the logical boundaries rather than the imposed viewpoint as to what the boundaries should be.
HUT-005

Therefore, the commission recommends that:

5. a. **regions or local communities establish advisory boards to the regional general manager and municipalities; the meetings of the advisory boards to be open to the public; and**
   b. **community-based care provider boards, if established by caregivers, be given the power to fix budgets as well as plan and deliver services within the overall authority of the regional general manager.**

• *Clarity of Vision and Mission*

This commission believes that agencies with clearly stated ***goals and objectives***, with a clearly stated mission, are more likely to be successful in serving the public and less likely to be influenced politically.

Currently, the ministry has few organizational goals and only a limited vision for the future. While some programs have fashioned their own mission and the ministry has developed a strategic plan, the plan is still under consideration and the ministry is operating without specific health goals. This leads to confusion throughout the system.

> *There currently exists*
> *a lack of clarity about what is expected*
> *of health care managers*
> *and*
> *there are few incentives in the present environment*
> *that encourage innovation*
> *in management.*
> EDU-011

Therefore, the commission recommends that:

6. **the Ministry of Health complete and publish its strategic plan.**

The commission considered making the Ministry of Health a crown corporation in order to consolidate management and separate it from politics. There are advantages and disadvantages associated with such a change; however, we do not believe that we have the information needed to support a recommendation of that magnitude at this time.

• *Reward and Training Systems*

Many good managers do not join the public service because the pay is too low and the rewards are too small. Others leave for the private health care sector and never return. If the ministry is going to find regional general managers who are competent and have the respect of the health care industry, salaries will have to be competitive.

New Zealand has recognized this problem and exempted regional general managers from the public service pay scales. It now pays them under State Service guidelines, similar to a crown corporation scale.

Managers in the public sector need well developed political and managerial skills. They must know how to negotiate, get consensus and operate effectively in an environment filled with lobbyists, media and single issue constituencies. Senior federal public servants in the United States receive training in these skills through the Federal Executive Institute.

But, at present, the Ministry of Health does not participate in career planning with its managerial staff, and only offers a small allowance of $30 per person per year for professional development.

Therefore, the commission recommends that:

7. The Ministry of Health invest in its future managers by funding professional training, career path development and financial rewards.

Managing Tertiary Care

The management of the tertiary care provided by the major BC hospitals is critically important for the whole province. It is a function that should directly involve the Ministry of Health and should not be left to the tertiary care hospitals themselves.

The efficient and effective management of tertiary care services is complicated by two very basic problems.

- There is no consistent or widely accepted definition of what constitutes tertiary care.
- There are no consistent or widely accepted data on the use of tertiary care services.

If the amount and nature of tertiary care provided in the province were clearly identified, the information might then be used to project future requirements for a given area or population. The cost per unit of care delivered, which is currently unknown, could then be measured on a local health area or regional basis.

Table One summarizes the bed use data for fiscal year 1989/90 for selected Vancouver hospitals. The proportion of days of care provided to those from outside the Greater Vancouver Regional Hospital District (GVRHD) is a rough indication of the amount of tertiary care services each hospital provides.

TABLE ONE

CASES REFERRED TO TERTIARY CARE HOSPITALS FROM OUTSIDE THE G.V.R.H.D.
1989/90

HOSPITAL	Total number of cases	% of cases from outside GVRHD	Total days of care provided	% of days of care provided outside GVRHD
Children's	7,616	34.7	67,420	41.2
Vancouver General	25,379	24.3	249,968	22.9
University (UBC)	8,878	26.0	84,892	21.8
St. Paul's	16,843	21.2	154,534	21.4
University (Shaughnessy)	11,522	16.8	104,084	16.2
Grace	8,741	9.3	38,976	15.1

SOURCE: Greater Vancouver Regional Hospital District.

The data indicate, for example, that, despite the relatively even distribution of the two populations, most of the tertiary level maternity care at Grace Hospital is being provided to Lower Mainland residents. The care being provided to residents from outside the Lower Mainland appears to be at a very intensive level.

Therefore, the commission recommends that:

8. the province undertake a comprehensive and thorough analysis to determine the nature, amount and cost of tertiary care being provided by BC hospitals.

9. the Ministry of Health, in consultation with hospitals and clinicians,
  a. establish tertiary program objectives; and
  b. plan, coordinate, monitor and evaluate the delivery of tertiary services and report the results.

The multi-dimensional aspect of the mission of these hospitals influences their character, their purpose, their operations, their structure, in a way that requires them to be dealt with differently.
EDU-032

* GLOSSARY

These type of services require well trained, highly dedicated, nursing staff, and there is a severe shortage of nursing staff in the province, particularly in the medical/surgical intensive care units of the tertiary care hospitals.
HOS-041

The current management of the tertiary services provided by BC hospitals has been described to the commission as lacking goals, being unaccountable to the public, poorly planned and poorly organized. These problems highlight the need for better management, and we have identified three basic options.

- Leave things as they are. Let those people involved try to work out the problems among themselves with a minimum of government interference.
- Amalgamate all tertiary care hospital boards in a region into a single board responsible for planning, coordinating and delivering primary, secondary and tertiary care, as well as community health services.
- Alter the system so that the delivery of specific types of tertiary care is coordinated by an organization other than the hospital boards.

As discussed in ***Hospitals***, a hospital must not unilaterally decide to initiate or conclude tertiary care programs. Hospitals must negotiate with the province to downsize, open or close a program. Therefore, under either of the last two options, BC hospitals would have to establish what tertiary care each would provide in an effort to ensure the rational delivery of services.

The commission believes that, as tertiary care services are paid for by all British Columbians, they should be readily available with minimal delay to everyone in need. This is not an easy task for the hospitals which provide tertiary care. They must integrate that objective with providing better and more efficient health care for residents within their own regions. Their task will be greatly aided if each region can identify the nature and cost of its extra-regional tertiary care requirements and thereby participate in the management of the tertiary care system.

Therefore, the commission recommends that:

10. a. hospital boards retain their current autonomy subject to regional control for the provision of primary and secondary services, but be subject to the direction of the ministry for tertiary care services;

b. the cost of tertiary care services to individuals be charged to their region; and

c. the nature of what constitutes the tertiary care that will be funded be narrowly defined by the ministry.

Managing Vancouver Hospitals

The commission does not have enough information to decide whether all of Vancouver's hospital boards and health care societies should be amalgamated into a single board. However, as Vancouver hospitals work closely with the ministry in the planning, coordination and delivery of tertiary care, they may find it necessary and useful to move toward a single board structure. Such a structure may be particularly useful for the city's teaching hospitals. The commission is not alone in this belief; consolidation was recommended by one of the existing Vancouver hospital boards.

Waiting Time

Public perceptions about waiting lists are shaped, in large part, by news media reports of backlogs for open heart surgery and certain cancer treatments, and by reports of staff shortages in hospitals. The accuracy of the reports, usually based on the anecdotal evidence of patients who find themselves having to queue for certain procedures, is questionable. Although there are backlogs for some procedures, there is no valid way to objectively determine the length of the current waiting lists – not for the government, and not for the news media.

The basic issue in any discussion of waiting times is equity of access to medical services. Despite a low response rate of 24 percent, a 1990 study estimated the total number of people on the provincial surgical waiting lists at over 45,000. It also reported that 2,179 patients were waiting for cardiac surgery. However, the province, using statistical information based on admission records and the records of individual surgeons, reported that 25,000 people were waiting for surgery in April, 1990, 781 of them waiting for cardiac surgery. These statistics include, at best, the number of patients, the diagnosis, the procedure and the surgeons. A media news report in the spring of 1990 claimed that over half of the patients waiting for heart surgery belonged to two of the province's 15 cardiac surgeons.

A ministry study indicates that for about 70 percent of inpatient and day care surgeries, the waiting period is up to eight weeks. Another survey indicates that facilities outside the Lower Mainland have much shorter times.

Some of the major factors which contribute to the current problem are that:

- some specialists have better reputations and, as a consequence, receive more referrals
- general practitioners are likely to continue to refer to the same specialist
- unless they know the length of a specialist's waiting list, general practitioners may continue to refer to that specialist not realizing that their patients may be put at the end of a long line
- the systems for compiling waiting list information are incompatible
- most BC hospitals compile wait list information manually; only two use computers
- there are periodic shortages of highly trained technicians
- certain services, for example, prosthetic surgery, have been rationed by the hospitals to control part of their global budget.

Although long waiting times for high-tech, life-and-death surgery, elective procedures for joint replacement, back surgery and cataract surgery generally receive the most news media attention, a number of other procedures have been cited to the commission. These include radiotherapy, occupational therapy, physiotherapy and speech therapy, particularly for children. The long-term effect of delayed access to these services may be considerable for the individual and the health care system.

We were constantly looking for speech pathologists, audiologists, and we would go for two years sometimes without having those positions filled. The waiting list became incredible.
BCG-014

• *A Surgical and Diagnostic Registry*

Timely and adequate information should be used to match patients with the first appropriate available surgeon and facility. To do this, the province needs a standardized computer system to compile and analyze data and make it accessible to facilities, physicians and patients.

In 1990, the Ministry of Health committed itself to implement a Provincial Surgical Registry. The Registry is expected to be based on consistent, uniform data collected from all hospitals. The proposed data items will show if and where the surgery was performed, if not, why not, and whether the patient is still actively on the waiting list. They will include:

- the patient's name and identifier number
- the patient's address
- the day care or inpatient identifier
- the degree of urgency
- the specialty performing the procedure
- the name of the surgeon
- the location of the service in the hospital, for example, in the day care surgical operation room
- the primary procedure and basic description
- the date the patient went on the waiting list
- the date the patient came off the waiting list
- the reason the patient was taken off the list.

The commission thinks that the confidentiality of patient-specific information on the registry should be maintained by the Ministry of Health and not be released to the public. However, aggregated data could be published in the form of an annual report.

The registry will be ready for testing in three hospitals by July/August 1991. It will provide more objective, up-to-date information than has been available in the past, to help the ministry and hospitals allocate resources and influence the system of referrals. The ministry has indicated that it has no intention of using the registry as a *triage tool with mandatory referral to available surgeons; it intends that the traditional referral patterns of physicians will be respected.

The commission thinks that for people in BC to have timely and adequate access to surgical procedures, the information collected for the Provincial Surgical Registry should be used to match patients with surgeons and facilities. The registry should offer a patient the opportunity, in consultation with the referring physician, to use the next available surgeon. Data generated by the registry could be linked to physicians' billing computers, providing them with information on the waiting lists and waiting times for particular procedures, surgeons and hospitals. This would not only improve equality of access, it is also consistent with the right of informed choice that is essential for patient autonomy.

The ministry has also indicated that the Provincial Surgical Registry *may* consider quality of care issues and outcome analysis at a later date when the work being done on a provincial basis through the Clinical Management Research Advisory Committee is complete. The commission, however, considers that outcome analysis should be a *priority* of the registry, particularly during the developmental stages, to ensure that data will be collected for evaluation purposes.

We think that criteria should be developed to decide what procedures should be included in the registry. Standards should be set to determine the maximum waiting time expected for the procedures included in the waiting list data. Performance of the system should be tested against acceptable waiting times and corrective action taken. There should be particular attention paid to planning for day surgery.

In considering the best way to assemble information on waiting times and to manage waiting lists, the ministry should review the experience of the BC Eye Bank which we have been told has developed a sophisticated program for this purpose.

The commission expects that the availability of information about waiting times will result, when there is delay, in corrective action by the ministry if it is a tertiary procedure, and by the regional general manager if it is not a tertiary procedure.

Therefore, the commission recommends that:

11. **the Provincial Surgical Registry be changed to a surgical and diagnostic registry including a computerized waitlist showing the availability of hospitals and specialists, the waiting time for procedures and other details.**
12. **standards be established to determine the maximum waiting time for different procedures and performance be tested against these standards.**
13. **information in the registry be available to researchers and the general public, subject to privacy and confidentiality rights and exceptions prescribed by regulation; and be available to health care managers for their guidance and to physicians to assist them in advising their patients.**

The commission also believes that the Coroners Act and the Human Tissue Gift Act should be reviewed and amended to make it easier to achieve a higher rate of tissue and organ retrieval and transplantation and to reduce waiting times. This review should be done in consultation with specialists from the Pacific Organ Retrieval Program and the Eye Bank.

Open Heart Surgery

The waiting list problem most often reported in the news media is for open heart surgery, in particular coronary artery bypass surgery, which accounts for 70 percent of all open heart surgery in the province. This surgery involves a large number of medical and nursing disciplines, as well as expensive technology. And it raises serious management questions as well as political, economic, legal, theoretical and personal issues. In 1989, 4,961 British Columbians died as a result of coronary artery disease; 3,016 of those people were over 75 years old.

- 71 percent of open heart patients are male
- coronary artery bypass surgery accounted for 76 percent of all open heart surgery for men and 49 percent for women.

Life was suspended,
literally,
because he sat in
a chair looking at
the phone for over
a month,
because we were told
to be home when
the phone call came.
IND-343

Prior to 1991, Vancouver General, St. Paul's and Royal Jubilee Hospitals provided BC's entire capacity for adult open heart surgery. Royal Columbian Hospital started its program in 1991 and the current provincial capacity for open heart surgery is about 2,000 cases per year. (Children's Hospital does paediatric open heart surgery on an *as needed* basis.)

Each coronary artery bypass operation costs the government about $15,500. Including surgeons' fees, the total annual cost for adult open heart surgery in the province is about $35 million. Since 1983, the four major hospitals have fallen 1,170 cases short of the number of cases funded by the ministry, and some people are reported to have died while on a waiting list for surgery. This shortfall is mainly due to a lack of staff and the ministry has responded with various initiatives to increase service capacity.

The commission surveyed the three hospitals which had open heart programs in place prior to 1991. We requested information from the hospitals for every open heart patient treated in a 12-month period during 1989 and 1990. The survey showed that:

- of the 1,909 open heart procedures performed: 20 percent were done at Royal Jubilee, 29 percent at St. Paul's and 51 percent at Vancouver General Hospital
- the average length of stay in hospital was 13.2 days at Vancouver General, 16.3 days at St. Paul's and 17.4 days at Royal Jubilee Hospital
- post-operative mortality rates were 3.5 percent at Vancouver General, 5.7 percent at St. Paul's and 6.5 percent at Royal Jubilee Hospital
- certain regions of the province had proportionately more open heart surgeries than others.
- regional differences exist for specific age groups: the number of open heart operations performed on adults between the ages of 50 and 59 per 100,000 population was 290 in Victoria, 140 in Vancouver, 120 in Peace River and 80 in Prince George.

These are very wide variations and they raise questions about access to services, quality of care and the appropriate use of a scarce and expensive resource. It appears as though the need for open heart surgery could be better met by using the present resources more efficiently.

ALTERNATIVE DELIVERY ORGANIZATIONS

The current interest in alternative health service delivery organizations – community health centres (CHCs), health service organizations (HSOs), centres locaux des services communautaires (CLSCs) – is only the latest attempt to establish and promote alternatives to *fee-for-service medicine. Quebec's Castonguay-Nepveu Commission recommended the development of Alternatives in 1972, and a number of CLSCs have been operating in that province as a major part of the health care system since the early 1970s. Elsewhere in Canada, however, Alternatives have been less successful in establishing themselves, despite the Sault Ste. Marie Clinic, founded in the mid-1960s, the federal government's ***Community Health Centres in Canada*** report, 1972, and "official" acceptance by the Ministry of Health in Ontario in the early 1980s. Alternatives have become popularized in the United States under the label of health maintenance organizations (HMOs). The most successful American HMOs go back to the 1940s when they were known as prepaid group practices.

The advocates of alternative health service delivery organizations have a number of objectives:

- to contain the cost of health care
- to make health care more accessible
- to link health care more closely to *health outcomes
- to shift emphasis from curative to preventive services.

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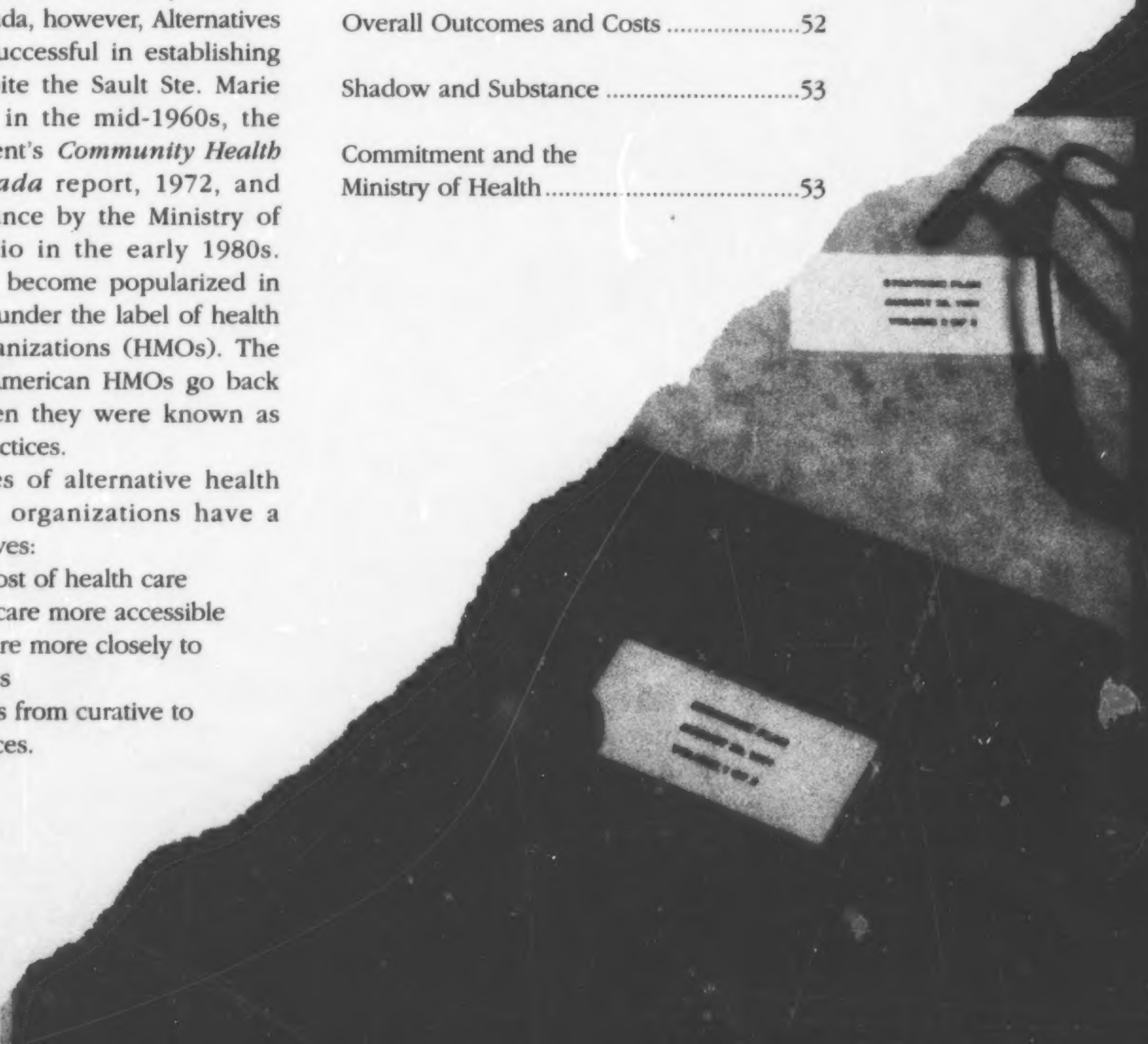

Alternatives all provide outpatient medical care, but they are typically financed either through payments based on their number of enrollees, like the Ontario HSOs or the American HMOs, or through negotiated budgets, like CHCs in Saskatchewan. Staff, including physicians, are paid on a salaried or sessional basis.

There is no particular reason why Alternatives cannot work in a fee-for-service system. The world renowned Mayo Clinic in Minnesota can be described as an alternative delivery organization based on a very sophisticated management structure that charges fees. But the fees it charges are not linked to the services of particular staff members.

In conventional fee-for-service practice, the revenues of a medical practice depend on the billing activities of one particular class of practitioner, or physician, who owns the practice and employs everyone else. Decisions about the range of services that will be provided and who will be employed have a direct effect on the personal income of the physician or physicians owning the group, and the effects have to be taken into account. This means that the physician's authority is economic as well as professional.

In Alternatives, the revenue of the organization is no longer simply the fees paid to physicians, so the direct financial link between their activities and the survival of the organization is severed. This means that Alternatives are able to offer a wider range of services and to employ a wider range of personnel, including substitutes for physicians such as *nurse practitioners. Although it is difficult to generalize, such a system usually leads to a philosophy of care which emphasizes teamwork, *health promotion, community development, non-physician administrators, community boards and volunteers.

Definition

There are, we believe, two distinct ways of defining and understanding the general category of alternative health service delivery organizations. These distinctions lead to very different expectations as to how Alternatives should operate and how they should be evaluated. In essence, some Alternative advocates view them as a way to expand the range of "medical" services, as described under the Canada Health Act, while others emphasize that they reduce the range of "necessary" services.

Those who want to expand medical services stress the success of Alternatives in reaching out to people who find access to mainstream health care difficult for social, cultural, or ethnic reasons. A substantial number of small clinics have grown up in different parts of Canada, providing care for low-income people, transients, youth, Native groups, and residents of isolated or rural communities. Moreover, since specific illnesses or injuries are often consequences of underlying problems of social adjustment, these clinics try to get to the roots of the problem, rather than simply treating the presenting complaint. They see themselves as improving the quality, effectiveness and equity of the system.

On the other hand, the main thrust of HMOs in the United States, and of their many imitations in western Europe, has been to reduce the total cost of health care by changing the way in which health care is organized in communities. To this group, Alternatives are not just for underserved people, but also for the average citizen. They emphasize decades of extensive and consistent research which shows that in organizations paid by *capitation – so many dollars for each enrollee every year – the use and cost of health care falls, while quality of care and health outcomes stay the same. According to these groups, this occurs because capitated Alternatives are less likely to provide unnecessary care. But to succeed, they must penetrate mainstream health care on a large scale, not just fill in the gaps in the system.

These two positions – expanding medical services or contracting necessary services – are not mutually exclusive. The commission received a number of briefs from alternative health service delivery organizations, either operating or organizing in BC, stating that they save money and provide better quality care for the populations they serve. Yet they are still not recognized or supported by the ministry as important parts of BC's health care system.

> *Alternatives provide an opportunity*
> *for improved case management.*
> *Salaried practitioners know*
> *of and use other community support services*
> *and referrals more appropriately.*
> *There is more frequent monitoring*
> *of patients in their home and community.*
> *There is no incentive to hospitalize patients.*
> *Salaried staff can spend more time*
> *with special need clients*
> *and provide health education on the spot.*
> *Duplication and overlap of services*
> *is reduced through service coordination*
> *and integration; and improved quality*
> *of life results through local empowerment*
> *and community involvement in decision-making*
> *surrounding the development*
> *of local solutions to the physical and social issues*
> *that affect health.*
> SOC-155

Claims that Alternatives can extend services to better meet the needs of the community while substituting personnel and lowering costs are highly controversial, not least because they are a very direct criticism of fee-for-service practice. In this general atmosphere of advocacy and hostility, it is important to be clear about what is already known about Alternatives, and what is not known.

Use of Hospitals

A large number of studies, from the 1950s to the 1980s, have consistently shown that in both Canada and the United States, physicians in organizations paid other than by fee-for-service are much less likely to hospitalize their patients. Some studies show a reduction in inpatient use by as much as 20 to 40 percent. As this reduction has not coincided with either underservicing or selection of more healthy patients, we believe that these studies confirm our view, expressed in ***Hospitals,*** that the current payment system is a contributing factor to hospital use.

Studies in Olmstead County, Minnesota, whose residents are served by the Mayo Clinic, show rates of hospital use which are lower than those for the general population, and which are similar to those of the leading American HMOs. These studies not only confirm that lower hospital use is consistent with high quality medicine, but they also suggest that good internal management in an organization, combined with relieving the individual practitioner of financial pressure, is more critical to providing high quality care than whether or not the clinic itself is paid by fees.

The Use and Costs of Outpatient Care

Research is less extensive and the findings are less consistent on the use of outpatient care visits, consultations, diagnostic services and prescription drugs. Advocates argue that physicians have less financial incentive to overtreat in an Alternative, and will be more willing to delegate care to other personnel, thereby lowering costs.

But studies of community health centres in Saskatchewan and Ontario indicate that outpatient physician visits are higher in CHCs. Overall staff costs for each patient are also higher because lower physician costs are more than offset by the cost of additional personnel. Advocates argue that this comparison is unfair because CHCs provide more services of different kinds, but an add-on to the present system is still an add-on.

The American evidence is also ambiguous. While HMOs do seem to make more use of substitutes for physicians, cost savings in *ambulatory care similar in scale and consistency to those in hospital use have not been shown.

The Saskatchewan data do show significantly lower rates of prescription drug use among CHC patients, particularly among the elderly. This is an important point; many *submissions to the commission state that the overuse of prescription drugs by the elderly is a significant health problem in BC. Some physicians told us that in a fee-for-service system, there is pressure on physicians to keep patient visits short in order to keep billing volumes up. Writing a prescription or ordering a diagnostic test is a quick and acceptable way of ending an interview. Supporters of Alternatives argue that in an alternative health service delivery organization, physicians would not have that pressure and would, therefore, see fewer patients each day and write fewer prescriptions. And that is what most studies find.

Preventive Services and Health Promotion

There is some evidence from Ontario that staff in CHCs are more likely to believe and report that their form of funding favours health promotion. They are also somewhat more likely to provide health promotion services, and to employ more health promotion staff. There is, however, no evidence that their patients are healthier as a consequence, or that their overall costs are lower as a result of healthier people needing less curative care. On the contrary, Ontario's data suggest that more health promotion is associated with more servicing and more costs.

Overall Outcomes and Costs

The fact that Alternatives are able to reach undertreated groups suggests that they must have some positive effects on the population's overall health status. But we are not aware of any hard data to support the view. No evidence exists, for example, that moving half of the population now served by fee-for-service physicians over to alternative health service delivery organizations would improve the overall *health status of British Columbians.

At the same time, most of the evidence on the cost of care suggests that the savings in hospital use are large enough to out-weigh any possible increases in ambulatory care costs, particularly if savings in the use of prescription drugs are included. A widely quoted Seattle study, in which patients were randomly assigned to receive care from an HMO or from the regular fee-for-service system, with full insurance in both situations, showed that per patient savings of 40 percent in hospital use translated into a 28 percent savings in overall costs. A recent study in Saskatchewan showed total savings of 13 percent and 17 percent for two clinics studied.

Shadow and Substance

The available evidence seems quite conclusive that, relative to conventional fee-for-service medical practice by self-employed private practitioners, alternative forms of care organization can lead to both better outreach to underserviced groups and lower overall costs of care. But simply substituting budgets or capitation contracts for fee-for-service is no guarantee of improvement.

In Ontario, a group of physicians may apply to be designated as a health service organization and be paid on a per patient basis for a defined roster of patients. But if the physicians build their roster from relatively healthy patients whose billings are below the provincial average to start with, then the members of the HSO may be paid more than before, for doing the same or less work. Monitoring the roster itself can be a problem; patients may move, or die, or be moved to fee-for-service, and there is no financial incentive for the HSO to keep the roster up to date. This is the same "cream-skimming" of patients which occurs in private insurance plans, described in ***Careful Spending***.

Even if some mix of Alternatives does lead to a reduction in use and cost for the populations they serve, this does not necessarily lead to a reduction in overall use. If one group of physicians reduces its use of hospital beds, others may simply admit more patients. A change in service patterns for one group of patients may, therefore result in an offsetting change for another. Indeed, there has been no observable effect on the overall use or costs of health care in the United States after 20 years of official encouragement of cost effective HMOs.

We have referred to outcome drift in ***Careful Spending*** and in ***Hospitals,*** whereby the interaction between providers and patients is a source of psychological satisfaction that becomes defined as a health outcome. Health and happiness contribute to each other, but they are not the same thing. Medically necessary services, for the purposes of a public health care insurance system, must be more narrowly defined.

Commitment and the Ministry of Health

We believe that there is enough evidence and track record that community health centres can reduce institutional costs and maintain the quality of care. This alone should be of interest to the government.
SOC-155

Alternative health service delivery organizations are anomalies in BC's health care system. They do not fit into an overall government strategy, nor are they a visible part of the ministry's agenda. There is no dedicated funding for them within the ministry, no goals, objectives or policies to guide them, and no information systems to support their success.

Alternatives can develop with staff from other areas, and they can be funded from MSP. But, right now, their survival is largely dependent on the enthusiasm of a group of dedicated professionals; commitment within the ministry is missing.

Alternatives typically attempt to integrate other health providers with physicians. At present, however, funding for CHCs is based solely on units of service provided by a physician and methods for future funding are still not clear. While the ministry has put $200,000 into CHO pilot projects, it is too early to estimate what additional monies will be needed to complete the development and preoperational phases.

In making a commitment to diversity in how medical services are provided in BC, the ministry must recognize the fundamental distinction between expanding what is medically necessary and reducing what is unnecessary. If the intent of Alternatives is to fill gaps, to reach more people and to offer more and different kinds of services, then the province should not expect to save money. If, on the other hand, the intent is to provide care more efficiently and effectively to people already being served by the health care system, then Alternatives must be evaluated strictly on their ability to reduce the levels of use of services for the populations they care for while providing quality care.

Ontario recognizes this distinction through a dual program. Health service organizations, reimbursed by capitation, serve the mainstream population, and savings are anticipated principally through lower rates of hospital use. Community health centres are given budgets and are expected to reach underserviced populations with a broader range of services. In Quebec, the centres locaux des services communautaires serve a large proportion of the total population and current proposals are for their expansion.

We believe that the evidence for potential advantages from diversification in the organization of medical practice is sufficiently strong that the Ministry of Health should be making a more serious effort to encourage alternative health service delivery organizations.

In the past, a number of physicians and their organizations have been quite hostile to Alternatives. Some of this hostility persists. The commission has been told that Alternatives will simply add another layer of unnecessary bureaucracy to the health care system, and that fee-for-service is efficient and fair, rewarding the physicians who work hardest and who satisfy their patients. Fee-for-service is also seen by many physicians as the form of practice which gives physicians the most freedom from government direction.

We believe, however, that much of the physician opposition to Alternatives is merely an echo of past conflicts that have occurred both in Canada and in other countries. We heard from a number of physicians who would like to work on salary or sessional arrangements, but do not have the option to do so. These physicians see Alternatives not as the heavy hand of government imposing unwanted and unsatisfactory forms of practice on a hostile profession, but as the opportunity for more freedom both in the style of medicine they practice and in their personal lives. The fee schedule is not a guarantor of autonomy and economic success for them. It is a treadmill.

This is the spirit of the commission's recommendation. No one in this day and age could seriously propose to shift all physicians away from fee-for-service. But we believe that a significant number of physicians, and patients, would prefer alternative health service delivery organizations to the present system. For them, Alternatives are not a threat but an opportunity.

To date, the ministry has not actively asked physicians to be involved in developing Alternatives. Fearful that they will boycott Alternatives completely, the ministry has allowed them to stand outside the planning process. But this could seriously affect the Alternatives' potential as agents of change; if physicians are not involved, they cannot contribute to and will not adopt the philosophy of the new system.

The BCMA says that it is willing to "provide a leadership role in the set-up, operation on a pilot basis and evaluation of any acceptable system of health care delivery." It also suggests that "physicians are prepared to accept these roles and responsibilities, but where they do, must be paid adequately for this work."

The BCMA represents the economic interests of physicians, and is understandably concerned that Alternatives might lead to reduced incomes for their members. And we understand that some of the Alternatives in Canada have survived primarily because very dedicated physicians have accepted incomes below those of their colleagues, so that other types of personnel could be supported by the organization.

Professional employment has many sources of satisfaction, of which income is only one. But we do not believe that alternative health service delivery organizations can ever come to represent a significant part of the health care system if participating in them means large economic sacrifices. The benefits of Alternatives can and must be gained through improved efficiency and more appropriate patterns of care, not through reducing provider incomes.

The time for pilot projects is long past. Continued monitoring, evaluation, and management are important, as they are for all the other components of the health care system. But the need now is for programs.

Given its other responsibilities and the diversity of interests which it represents, the BCMA may not be in a position to provide a leadership role in organizing, establishing, and evaluating alternative delivery organizations. However, it should be encouraged to try, as should any other group with a serious interest and some indication of capability.

Without close cooperation and enthusiastic support by physicians, no form of service delivery is likely to be successful. This does not mean that all or even a majority of physicians in an area must be in support. We have been told more than once that achieving a consensus among physicians on anything is a remarkable achievement, let alone on changes to traditional modes of medical practice. But physicians must be involved in developing and operating Alternatives and their participation must be supported.

Therefore, the commission recommends that:

1. **the Ministry of Health**
    - a. **make a commitment to develop alternative health service delivery organizations (Community Health Centres, Health Service Organizations, etc.);**
    - b. **shift resources to the development of alternative health services delivery organizations which have the potential to reduce hospitalization and increase the quality of care available at the community level; and**
    - c. **oversee the development, coordination and integration of the policies, procedures and possibly legislation needed to support alternative health services delivery organizations.**

Until recently there was a sense
that these organizations
were perhaps alright up in
the Queen Charlottes
or some isolated area,
or down in the depths of East Vancouver,
but they weren't
for ordinary God-fearing British Columbians.
HOS-032

HEALTH CARE SERVICES IN RURAL AND REMOTE AREAS OF BC

Three hundred and eighty briefs sent to this commission came from people living or working in remote or rural areas of BC. They indicated a number of problems that rural British Columbians have in receiving health care services, and reflect even more severe problems for those people living in remote areas.

> *We have no permanent radiologist.*
> *We have no internist.*
> *We have no paediatrician,*
> *obstetrician or gynecologist.*
> *No pathologist.*
> *We have no psychiatrist.*
> HCP-063

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This chapter addresses three issues raised by the briefs:

- shortages of rural area physicians and other health care workers
- survival of the rural community hospital
- costs associated with restricted access to care.

The Management of Health Care Services in BC addresses the concerns of British Columbians who want greater participation in the planning and distribution of the province's health care resources. ***Native Health*** addresses the problems that particularly concern Natives and Native communities.

In general, people from remote areas of BC suffer from higher than average rates of:

- infant deaths
- accidental deaths
- alcohol-related deaths
- violent deaths (suicide or homicide).

People from rural areas also die at higher than average rates in their first year of life.

The health of Native British Columbians from rural and remote areas is particularly grave. They suffer from higher than average rates of infant death, diabetes, heart disease, suicide, death through violence and alcohol and drug abuse.

People in remote and rural areas have fewer health care resources per capita than urban and metropolitan people, including fewer health care workers, fewer psychiatric beds; and no alcohol or drug detoxification centres. Whereas, in 1987/88, the Medical Services Plan (MSP) spent an average of $191 and $239 for physician services for people in remote and rural areas respectively, MSP spent $278 and $340 for physician services for people in urban and metropolitan areas.

RURAL AND REMOTE BC: 1991

REGIONAL HOSPITAL DISTRICT	TOTAL POPULATION	% BC	DISTANCE (from tertiary care centre)	TRAVEL TIME
REMOTE	251,793	7.88	>120 km	>1.5 hrs
RURAL	322,724	0.08	>120 km	<1.5 hrs
URBAN	801,782	25.03	<120 km	<1.5 hrs
METRO*	1,826,885	57.03	<120 km	<1.5 hrs
TOTAL BC	3,203,184	100.00		

1991 population estimates are projections based on the 1986 distribution.

* Metro has population centres greater than 100,000 and tertiary care centres.

Health Care Workers in Rural and Remote Areas

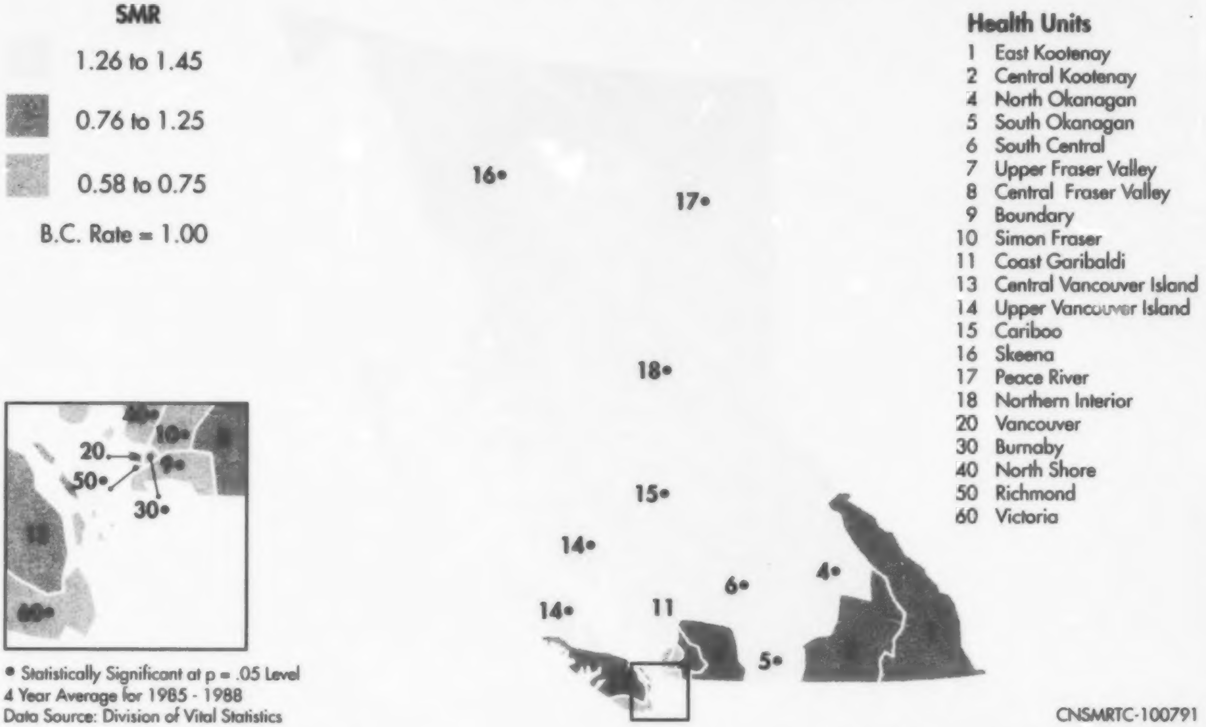
A shortage of health care workers is a reality for people in remote and rural areas of BC. This shortage influences the degree to which people can be returned to health close to their own homes and has cost implications for people who must travel at their own expense to receive services.

The supply and distribution of health care workers in the province vary by specialty. The more general providers (general practitioners, registered nurses, licensed practical nurses) are relatively evenly distributed, but the highly specialized providers (physician specialists, occupational, physical and speech therapists) are not. While the supply and distribution of general providers have improved, in many instances those of the more highly specialized (surgery, anaesthesiology, orthopaedics, internal medicine) have worsened.

In order to improve the supply and distribution of health care workers to remote and rural areas, the Ministry of Health, its regional general managers and local care-giver organizations must focus on those aspects of rural practice that discourage people from working in remote and rural areas. These include:

- lack of preparation for rural practice
- excessive workloads without relief or replacement
- social and professional isolation
- lack of opportunity for continuing education.

BC STANDARDIZED MORTALITY RATIO - ACCIDENTAL CAUSES BY HEALTH UNIT (See "Public Policies for Health")


SMR
1.26 to 1.45
0.76 to 1.25
0.58 to 0.75
B.C. Rate = 1.00
Health Units
1 East Kootenay
2 Central Kootenay
4 North Okanagan
5 South Okanagan
6 South Central
7 Upper Fraser Valley
8 Central Fraser Valley
9 Boundary
10 Simon Fraser
11 Coast Garibaldi
13 Central Vancouver Island
14 Upper Vancouver Island
15 Cariboo
16 Skeena
17 Peace River
18 Northern Interior
20 Vancouver
30 Burnaby
40 North Shore
50 Richmond
60 Victoria
16•
17•
18•
15•
14•
14•
11
6•
4•
5•
20
50•
30•
10•
9•
60•

• Statistically Significant at p = .05 Level
4 Year Average for 1985 - 1988
Data Source: Division of Vital Statistics

CNSMRTC-100791

Prepared by: Health Economics & Planning Branch, Ministry of Health

Map Source: Planning & Statistics Division, Ministry of Finance & Corporate Relations

In addition, rural and remote physicians have the frustration of referring a patient to an urban centre for treatment —contacting the specialist and locating a bed – only to lose the bed to a local emergency before the patient arrives.

Although the Ministry of Health has recruitment, retention and support programs, such as the Northern and Isolation Allowance Program (NIA) which pays rural physicians 6 - 20 percent more per patient visit than urban physicians receive, their efforts have been inadequate and the success of the programs is unknown. The few evaluations that have been done in other provinces show that traditional monetary incentives do not work as recruitment aids. More recently the ministry has turned toward strategies such as a *locum replacement program.

In Ontario, the Underserviced Area Program (UAP) supplies family doctors, specialists, occupational, physical and speech therapists, audiologists and podiatrists to remote and rural areas. UAP keeps health care personnel statistics, declares areas underserved, administers bursaries, grants honoraria to those who conduct in-service seminars and runs a locum replacement service on a budget of $11 million a year.

Occasionally, when a doctor is found unsuitable to a community because of self-imposed limitations, we are reminded that "we thought you were short of doctors" as if we should take any doctor who is drawing breath, compatible or not.

HOS-074

In Newfoundland, medical staff aboard oil rigs receive advice from Memorial University Medical School's Telemedicine Centre which has a 24 hour network linking 90 communities and 160 sites (hospitals, universities, schools). In rural areas of Utah, Idaho and Wyoming, rural physicians can transmit fetal monitoring strips over a facsimile machine to a *perinatologist in Salt Lake City and get an immediate response by telephone. Telemedicine is also used to link staff and patients at Ontario's Lakehead Psychiatric Unit with those at the Clarke Institute during grand rounds. Teleconferencing has been ranked as being as useful for continuing education as time spent in short courses.

Therefore, the commission recommends that:

1. **the Ministry of Health increase the number of health care workers in remote and rural BC by**
    a. **admitting students from rural communities to health care worker training programs;**
    b. **establishing health care worker training programs in rural areas as a priority for the Ministry of Health and the Ministry of Advanced Education, Training and Technology;**
    c. **funding rural specialty training in obstetrics, surgery, anaesthesiology, nursing, physical, occupational and speech therapy, and funding for rural clerkships; and**
    d. **moving a portion of health care worker training internships and residencies to locations in rural and remote BC.**
2. **the Ministry of Health establish a recruitment and retention program, similar in scope to Ontario's Underserviced Area Program, to**
    a. **evaluate current recruitment and retention efforts;**
    b. **support the development of locally designed recruitment and retention strategies; and**
    c. **recruit permanent and temporary replacement staff for remote and rural areas.**
3. **the Ministry of Health and the College of Physicians and Surgeons develop a communication program similar to Newfoundland's Memorial University Telemedicine Program, including**
    a. **computer access to data banks of health care literature;**
    b. **telephone, radio and telemedicine capabilities;**
    c. **telewriters (long distance blackboards); and**
    d. **medical data transmission (EEGs, x-rays, patient records).**

Several reports suggest that the supply of health care resources in BC could be improved by linking remote and rural communities with larger urban or neighbouring rural centres, or by linking organizations within the same community. This reorganization would encourage resource sharing and group purchasing, as well as offer greater recruitment capabilities, career enhancement opportunities, more stable access to non-resident medical staff and better service to patients. Rural hospitals affiliated with larger centres could gain management and educational support as well as greater control over patient referrals. Problems such as isolation and the availability of locums could be reduced by using one person to fill similar roles in different organizations. For example, *public health nurses could also work in hospitals and in *home care.

The Northern Isolated Area Travel Allowance Program (NITA) is a resource-sharing program already established within the Ministry of Health. Hospitals recruit visiting medical specialists and pay their operating overhead, NITA pays the specialist's travel expenses, and MSP pays for the assessment, diagnosis and treatment of patients. NITA, however, does not coordinate resources, supply non-physician health care workers to remote and rural areas, or play an educational role.

Outreach education in Canada is a function of the University of British Columbia's Faculty of Medicine and Ontario's UAP as well as the University of Manitoba's Northern Medical Unit (MNMU). The MNMU supports travelling surgical teams which perform surgery, stay on site for the post operative period and educate resident staff.

The structural and organizational changes outlined in ***The Management of Health Care Services*** and ***Careful Spending*** are designed to encourage resource sharing by institutions. However, the Ministry of Health must also remove restrictive funding policies and develop cross-ministerial funding mechanisms. They must revise regulations and contract clauses which limit reimbursement and staff protection, if and when staff work in other than their primary work place.

The loneliest caregiver is a primary nurse serving a remote community alone.
HCP-065

Therefore, the commission recommends that:

4. the Ministry of Health
  a. develop inventories of existing health services to facilitate locally designed resource-sharing proposals;
  b. allow savings realized through resource sharing to be retained locally;
  c. revise regulations and contracts which inhibit flexible use of staff across work settings;
  d. expand the Northern Isolated Area Travel Allowance Program into a travelling health care worker program similar to the University of Manitoba's Northern Medical Unit and Ontario's Underserviced Area Program; and
  e. make available an accreditation process for hospitals and organizations that is appropriate to the institution's size and mandate.

The Survival of the Community Hospital

The hospital's ability to provide basic medical services in remote and rural areas is threatened by staff shortages, people travelling to major centres for the higher risk procedures and thereby changing the hospital's funding base, and a changing patient population. These trends, combined with high *morbidity and mortality rates in rural communities, underline the need for hospitals and community health providers to form a strong partnership to provide comprehensive services to the elderly, Natives, mothers and newborns, and alcoholics. We understand that the Family Practice Committee on Teaching and Learning of Primary Care Obstetrics is considering proposals for family practice specialists with extra training in obstetrics, general surgery, psychiatry and anaesthesia. This approach could be of great benefit to small communities, and the commission, therefore, hopes that any proposal coming from the committee be given the most serious consideration.

Specific problem areas for rural and remote community hospitals are:

Anaesthesiology: General Practice/ Anaesthetists (GP/As) who work in rural hospitals that do not have enough work for a full-time anaesthetist are an aging group. Of 815 GP/As in Canada, 33 percent are over 60 years of age. BC has the second highest number (142) of GP/As, but the lowest ratio, rural to urban (61/81). Aging, along with the decision to extend GP/A's training from 6 to 12 months, will affect the future supply.

Surgery: Surgeons in rural practice require a wider range of skills than their urban colleagues. The aging of a large portion of today's rural surgeons, and the tendency away from comprehensive general surgery training within medical schools, will complicate the provision of these services in the future.

Until recently, many rural Canadian GPs went to other countries for added training in surgery. Such an option is not always available and the additional training needed to enable a general practitioner to perform surgery is not readily offered in Canada. This commission sees a need for people with additional training. It also believes that the criteria established for certification should be flexible and based upon patient outcomes.

Obstetrics: Between 25 and 42 percent of obstetric cases from remote and rural areas are currently being referred to urban or metropolitan centres. This commission would like to see this trend reversed. We would like to see babies being born in their own communities.

Obstetrics in rural and remote BC depends on the general practice physician and, to a lesser degree, the GP/As. General practice physicians are taking on fewer obstetrics cases than before, possibly due to fear of litigation, lack of training opportunities, inadequate financial compensation for the procedure, or a combination of all of these factors.

The Changing Nature of Care and Patients: Hospitals in remote and rural areas of BC are handling more medical cases and a different mix of surgical cases than in previous years. The advent of day surgery has been associated with a higher proportion of outpatient surgical cases. While *acute care beds are plentiful, low occupancy rates and average lengths of stay reflect a decline in the number of complicated and higher risk procedures performed.

Rural BC has virtually the same proportion of elderly people as more populous areas, but significantly fewer *long term care beds per capita. A greater proportion of hospitalized patients are now older than ever before.

Hospitals in rural and remote BC need to review their roles and establish in cooperation with the ministry, the regional general manager and local groups, the services and programs they will provide. This review should be influenced by:

- the hospital's role as a partner in a regional network
- the need for community based programs for high risk groups
- the need for alternative services for seniors
- the standards, quality of care and skills base required to deliver various levels of medical and nursing care
- the costs and benefits of providing care in one setting versus another.

Such programs must support shifting patient care from the hospital to the home or the community, as appropriate, and improve the efficiency of hospital bed use. Hospital mandates are discussed in ***Hospitals.***

Therefore, the commission recommends that:

5. the Ministry of Health
  a. contract with, fund, and hold institutions accountable for the provision of the services specifically outlined in their mandate;
  b. establish a rural hospital transition grant program to help rural hospitals become integrated health care centres; and
  c. provide funding to train or retrain physicians from remote and rural BC in FP/rural, FP/psychiatry, FP/anaesthesiology, FP/obstetrics and FP/surgery, and to compensate physicians in rural or remote practice for the lost time due to such training or retraining.

Costs Associated with Restricted Access to Care

Travel grants, which pay a portion of the round trip travel costs and accommodation for people who must leave their communities for necessary medical care, have become an important part of rural health care strategies in other provinces. The alternative is to improve the level of services locally by the introduction of a travelling health service and by the reallocation of urban hospital dollars to rural hospitals. This commission, however, believes that there will always be a group of BC residents who will have to travel. In 1989, 21,731 of 100,312 cases (21.6%) were referred out of remote and rural BC to hospitals in urban or metropolitan areas.

Edmonton is 700 miles away, it's 1000 miles to Vancouver, a person is paying between $250 and $500 to go to Edmonton, and up to $700 to go to Vancouver. And if you're a child or an elderly person, those costs are doubled.
RHD-017

While the data show that people are leaving their communities for treatment, they do not show why or by what route. An individual can claim for travel for medically necessary reasons on an income tax return, but claims may only be made where the total medical expenses are $1517 or exceed three percent of net income, whichever is less, limiting the tax credit to those who travel often. Revisions to the federal government's Northern Residents Tax Benefit Program eliminated the travel deduction that was once available, and few companies include medical travel costs as an employee benefit. The Ministry of Health pays to transfer emergency patients to regional centres, but gives nothing to those who travel due to a lack of services in their own community.

The criteria for a travel program should include:

- residency in an area where an insured medical service is unavailable within 250 kilometres by standard means of transportation
- physician referral for a medically necessary service
- referral to the most appropriate specialist or centre.

Therefore, the commission recommends that:

6. the Ministry of Health, as the provider of *tertiary care,

  a. establish a travel grant program for residents who must travel to receive medically necessary services, and to pay for an adult attendant to accompany a child or infirm adult;

  b. establish a central dispatch office to secure hospital beds on behalf of rural and remote area physicians and their patients;

  c. provide hostel accommodation for accompanying family members; and

  d. ensure that beds are available at all times for patients transferred from remote and rural areas.

This commission thinks that the needs of rural and remote areas will be better met when there are regional general managers responsible for those areas. However, we have not qualified our recommendations by stating that the various activities we suggest shall be carried out by the regional general managers because we do not wish a lack of action on one recommendation to be used as an excuse for a lack of action on others. Of course, we anticipate that most of the duties assigned to the Ministry of Health will become the responsibility of regional general managers.

AMBULANCE SERVICES

He fell 30-35 feet from a Hydro pole . . .

14:00 *Arrived at Clinic - quick head to toe assessment. Appeared to have fractured left ulna, radius, fractured right wrist and fractured femur. No head injuries noted.*

14:10 *Phoned provincial Ambulance... requested a helicopter in here within next hour if possible... I told Provincial (dispatcher) I wanted patient to go directly to PGRH [Prince George Regional Hospital] due to extent of injuries. (Dispatcher) stated that would be fine.*

16:20 *Phoned dispatch to find out where helicopter was and ETA. Stated they changed to a fixed wing aircraft and would arrive in 13-14 minutes: I had to then try and find a pick-up in the village, luckily co-workers knew of a pick-up that was in running order and went to get it to meet the plane and bring paramedic to the Clinic.*

17:10 *Arrival of EMA... I said he is to go to P.G. right? (EMA) said No and told me protocol of Prov. Ambulance is to take patient to nearest hospital and nearest hospital was Mackenzie. I said, this patient will probably need surgery... I had contacted Prince George... They are standing by...*

17:30 *I left the room and called Dr. [in Prince George] - he stated he would phone Provincial dispatch and sort it out if possible. ... the other RN, and myself ... had patient's BP up to 104/70 at time of discharge by IV infusion and warming. We felt he was in stable condition to reach PGRH.*

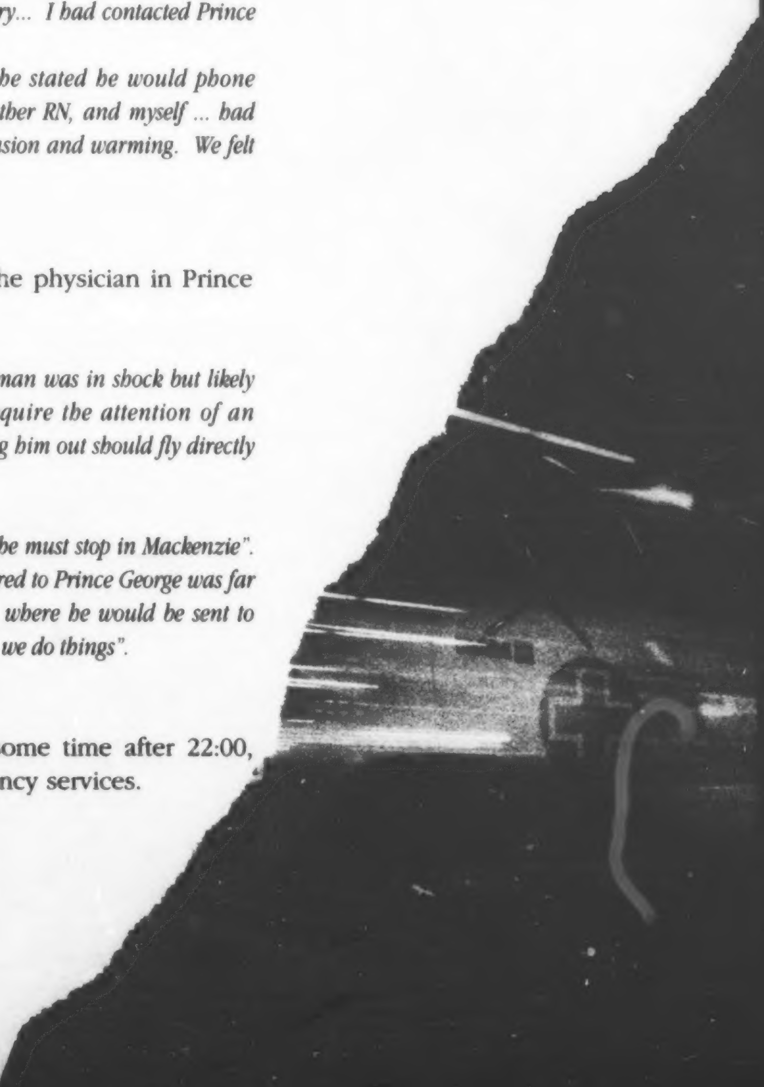
Nurse's Notes

This is recorded in the memorandum from the physician in Prince George:

> *... I called the dispatcher in Victoria and told him the man was in shock but likely stabilized; he had multiple fractures that would require the attention of an Orthopaedic Surgeon and that the fixed wing plane flying him out should fly directly to Prince George under the circumstances.*
>
> *He (dispatcher) told me "they would not allow this, that he must stop in Mackenzie". I explained that the extra 25 minutes of flying time required to Prince George was far more valuable than an assessment in Mackenzie from where he would be sent to Prince George anyway. He told me "sorry, that's the way we do things".*

Letter from the physician

The injured man arrived at Prince George some time after 22:00, eight hours after the call went out for emergency services.



The provincial Health Emergency Act establishes emergency health services and the Emergency Health Services Commission (EHSC). It provides for an ambulance service that is the envy of other provinces. The Commission's mandate includes:

- providing emergency services in the province and assisting others, including municipalities, to provide these services
- establishing a communication system
- training and licensing emergency medical assistants (EMAs) and other personnel.

The Commission is not an independent body, but a board made up of senior Ministry of Health employees.

The Emergency Medical Assistants Licensing Board, established under the Act, has the authority to examine, register and license emergency medical assistants and investigate complaints made against them. Regulations have been passed stipulating that all emergency medical assistants at level II or III must be employed by the EHSC. This restriction should be removed as it conflicts with municipalities and other organizations providing emergency health services as intended by the Act.

Therefore, the commission recommends that:

1. section 2(b) in Schedule B of the Emergency Medical Assistants Regulations pursuant to the Health Emergency Act be repealed.

Although ambulance service in BC is good, it could be better, particularly for small communities. According to the *submissions to this commission, the central dispatch system is inefficient and often unable to locate rural addresses. We were also told that emergency services policies often force health care workers to make expensive and time consuming decisions in the name of economy.

For example, in communities with runways, fixed-wing planes, which are less expensive to operate than helicopters, must be used for emergency airlifts, even if there is a helicopter on site. This supposed economy can result in expensive delays while fixed-wing planes are flown in from other communities, often to be turned back because they are unable to land at small, unlit runways. Such aborted flights often result in added physician and nursing time and cost.

We were also told that, in many communities, EHSC appears determined to stop firefighter ambulance services. In one community in particular, the city council, two hospital boards, the *regional hospital district, representatives of the Registered Nurses Association of BC and a number of physicians all told the commission that they support their existing firefighter ambulance services. They say that their fire fighters provide them with better service than EHSC, and at a more reasonable cost. This community, along with a number of others, is very anxious to retain its existing firefighter ambulance service, but EHSC remains unmoved. It intends to close all firefighter ambulance services by 1992 and replace them with what appears to be a less efficient, less popular and more expensive service.

> *Unfortunately, people in large cities have*
> *little concept of what is really effective*
> *in a smaller area such as ours,*
> *and it is our duty to attempt to educate them*
> *to the realities of the situation.*
> *I have no hesitation in recommending that*
> *our ambulance and fire service*
> *be maintained as at present.*
> PRO-046

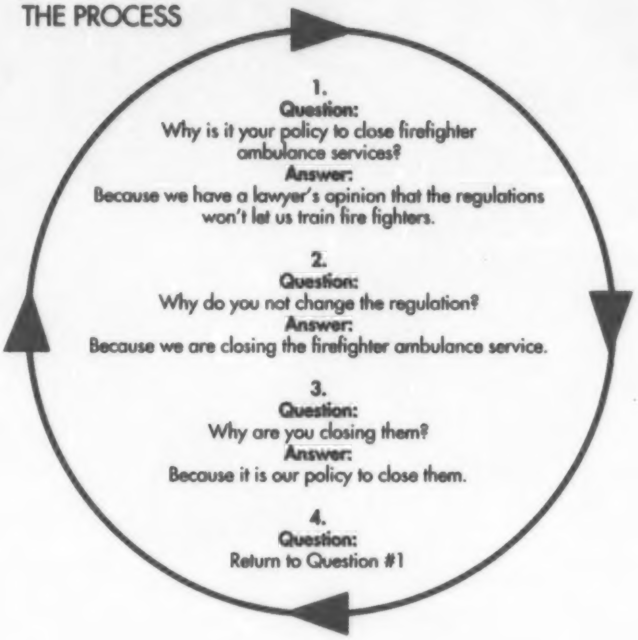
It is difficult to understand why the ministry supports the control of ambulance services being taken away from communities. It is even more difficult to understand the rationale of EHSC, whose explanations to the various municipalities and to this commission do not justify its stand. In one community, already served by emergency services, approximately 40 percent of the calls to the fire department are for emergency pre-hospital service. Why? They give "better coverage than the ambulance service [emergency services] and quicker response times..."

The reason the Canadian Union of Public Employees (CUPE) supports the control of ambulance services being removed from the communities is easier to grasp. CUPE wants to exclude members of the International Association of Fire Fighters from working as ambulance operators.

When fire fighters were scheduled to be trained in ambulance work at the Justice Institute in Vancouver, CUPE picketed the Institute and stopped the training. It has also commenced or threatened litigation to prevent the training of fire fighters in ambulance work, and, in some communities, has prevented fire fighters who are already running ambulances from being properly trained.

The commission believes that the local residents often know what is most appropriate for their community. And this commission believes that where a broad spectrum of groups unanimously endorses firefighter ambulance services, it is, at the least, inappropriate to frustrate the community will. We have difficulty understanding why, if fire fighters can and do give better emergency services, they should not perform those services and recover the cost from the Emergency Health Services Commission.

THE PROCESS



1.
Question:
Why is it your policy to close firefighter ambulance services?
Answer:
Because we have a lawyer's opinion that the regulations won't let us train fire fighters.

2.
Question:
Why do you not change the regulation?
Answer:
Because we are closing the firefighter ambulance service.

3.
Question:
Why are you closing them?
Answer:
Because it is our policy to close them.

4.
Question:
Return to Question #1

Therefore, the commission recommends that:

2. **provincial standards be maintained for ambulance services but that the management be decentralized by shifting control of ambulance services to the regions.**
3. **the Emergency Health Services Commission be made more sensitive to local needs by having members from communities that use firefighter ambulance services take the place of Ministry of Health personnel.**
4. **the use of fire fighters in the ambulance service be continued and, where appropriate, expanded.**
5. **the Emergency Health Services Commission bear the whole cost of training fire fighters for ambulance service and, if it is unable to give that training in British Columbia, bear the cost of obtaining the training elsewhere.**

PROTECTING THE PRINCIPLES OF MEDICARE

...the primary objective
of Canadian health policy
is to protect,
promote and restore
the physical and mental well-being
of residents of Canada
and to facilitate reasonable access
to health services
without financial
or other barriers.
The Canada Health Act

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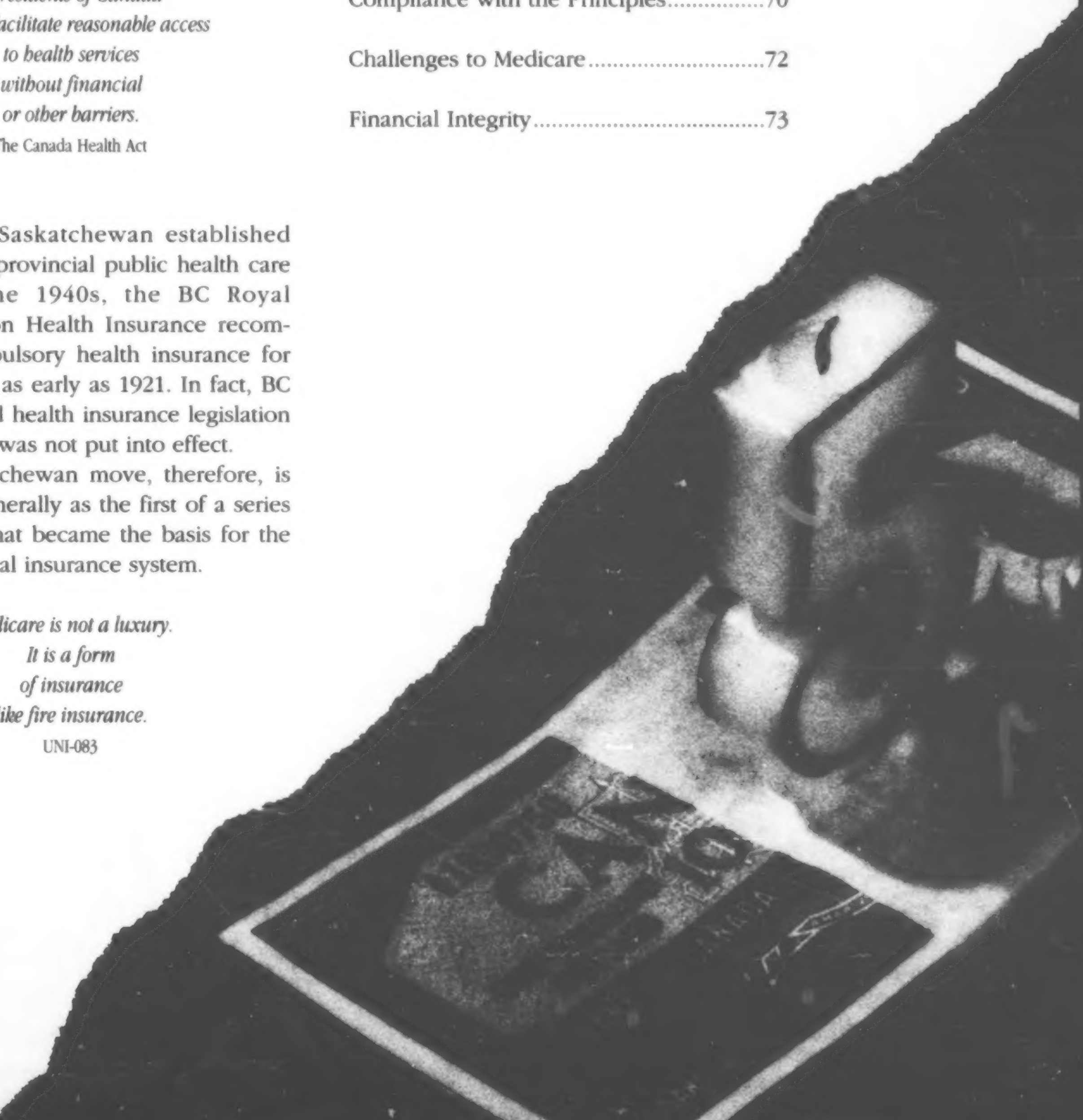
Although Saskatchewan established Canada's first provincial public health care system in the 1940s, the BC Royal Commission on Health Insurance recommended compulsory health insurance for some workers as early as 1921. In fact, BC actually passed health insurance legislation in 1935, but it was not put into effect.

The Saskatchewan move, therefore, is recognized generally as the first of a series of initiatives that became the basis for the national medical insurance system.

Medicare is not a luxury.
It is a form
of insurance
like fire insurance.
UNI-083



The federal government introduced the Hospital Insurance and Diagnostic Services Act in 1957 and, by 1961, shared-cost hospital programs had been established in every Canadian province. Following The Royal Commission on Health Services (Hall Report, 1964), hospital insurance broadened to include medical insurance.

To obtain federal funds under the Hospital Insurance and Diagnostic Services Act and the 1967 Medical Care Act, the provinces had to agree to uphold five principles:

- ***Comprehensiveness***
- ***Universality***
- ***Portability***
- ***Accessibility***
- ***Public administration.***

By 1971, every province and territory had accepted these conditions and had joined the national programs. Canadian medicare was fully operational.

Federal Financial Support

The federal government has always offered financial support to provincial health plans. At first, this support approximated a 50:50 sharing of costs. But that was changed in 1977 to a block funding formula, based on the average annual per person rise in the gross national product over the preceding three years.

This formula, contained in the Federal Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act, ended any link between federal expenditures and the actual health care costs incurred by each province. It also set the provinces free to spend the federal money as they saw fit.

However, during the late 1970s and early 1980s, there was a growing concern that the health care system was being compromised by various provincial governments. Mr. Justice Emmett Hall was commissioned once again, this time to consider the extent to which the goals he had identified in 1964 had been met. His 1980 report led the federal government to enact the Canada Health Act of 1984.

The Act consolidated the federal legislation of the previous 27 years and restored some federal influence over the direction of national health policy. It repeated the principles set out in the Hospital Insurance and Diagnostic Services Act and the Medical Care Act, but went further by clarifying what was meant by *comprehensiveness* and *accessibility*.

Under the Act, the federal minister of health can enforce compliance with the five principles of medicare, the ultimate penalty being the reduction or withholding of the federal cash contributions available through the Contributions Act. Withholding penalties can also be levied against a province which allows user fees for any insured health services authorized or permitted by the provincial health care plan, or which permits physicians to extra bill patients. The current level of cash transfers under the Contributions Act makes it uneconomical for a province to permit either of these – but the situation is changing.

Compliance with the Principles

- **Comprehensiveness** – No compliance problems were reported to the commission.

- **Universality** – Problems generally concern the use of health care insurance premiums.

Currently, premium rates are calculated by adding together one half of the estimated costs of medical practitioner Medical Services Plan (MSP) billings and the full cost of alternative health care practitioner MSP billings for the coming year. This amount is then divided by the projected number of people able to pay premiums for that year. Revenue from premiums amounts to about 50 percent of MSP payments and just over 13 percent of the Ministry of Health's total health care budget.

The commission identified a number of alternatives to premiums, but after considerable debate about these alternatives, we could not reach an agreement. Five of the six commissioners concluded premiums should be abolished, but could not agree on what should replace them. One commissioner felt the premium system needed only minor improvements and should not be abolished.

Therefore, a majority of the commission recommends that:

1. **health care insurance premiums be abolished.**

Three of the five commissioners supporting the abolition of premiums felt that the fairest and most appropriate measure with which to replace them would be a special income tax surcharge, linked to the total annual budget of the Ministry of Health. The charge would appear on both personal and corporate income tax forms as a Health Care Surtax.

These commissioners felt that linking a tax surcharge to the Ministry of Health's budget would provide individuals and corporations with a direct indication of the cost of the health care system. BC taxpayers would also be able to see the effect of the federal government's recent restraints. As less federal money is available, provincial income taxes rise to take its place.

While two other commissioners agreed in principle with that position, they felt that government would either be unlikely or unable to make such a change to the income tax system. They accepted the observation of Maureen Maloney, Dean of the Faculty of Law at the University of Victoria, that:

> *The payroll tax levy has the potential to be an efficient and equitable way to help finance the health care system. A more honest, but politically difficult way, would be a major overhaul of the federal and provincial income tax system. As this is unlikely to take place, the best provincial option may well be a payroll levy.*

The commissioner favouring the retention of premiums felt that initiating a payroll tax or increasing income taxes to replace the revenue lost from the removal of premiums would have a negative effect on business and employment. The commissioner also felt that there was value in a link – even if only a partial link – between the premiums paid by individuals and health care costs.

In the end, all six commissioners agreed that if premiums were retained, a system must be devised to ensure that no BC resident would be denied access to health care services.

- **Portability** - Problems arise when a BC resident travels to Quebec because there is no Reciprocal Billing Agreement between Quebec and the other nine provinces.

Therefore, the commission recommends that:

2. the government of British Columbia seek to establish a reciprocal billing agreement with the government of Quebec.

- **Accessibility** – Problems arise in many different contexts.
  - Because proportionately more specialists and *tertiary health care facilities are located in the Lower Mainland and southern Vancouver Island than elsewhere in the province, many people have to travel out of their communities to get the services of medical specialists. This means that they must pay considerable sums of money for transportation and hotel accommodation. The problem is worse for young children and the elderly, who must be separated from their families and who face a new and often frightening environment.
  - Access to health services is difficult in remote communities.
  - A fee is charged for using an ambulance.
  - A number of communities lack sufficient obstetrical care, and some pregnant women must leave for days or weeks during the final stages of their pregnancies to get the health care services they require.
  - There is an unequal distribution of health care workers throughout the province.
  - Some people have difficulty using services because of cultural differences or physical or mental disabilities.

These barriers are just as real to the people affected by them as the financial barriers which are described by the Canada Health Act.

User fees are popular in some political circles. However, studies have indicated that they have little effect on the use of the health care system by higher income groups and that they deter low income groups – the very people who need medical services the most, and for whom the system was designed to ensure access. User fees simply employ a different pocket to pay for health care services. Extra billing has an even greater negative effect on lower income families. Both of these topics are discussed more fully in ***Careful Spending.***

- **Public administration** – No compliance problems were reported to the commission. The Act does not prevent a health care facility from contracting out any of its services to private industry.

Therefore, the commission recommends that:

3. so far as possible,
  - **a. geographic and other financial barriers to health care services be eliminated; and**
  - **b. hospitals and other health care facilities eliminate cultural, physical and linguistic barriers to health care services.**

Challenges to Medicare

The five principles set out in the Canada Health Act raise several questions and face several challenges. Should the scope of the available services be broadly or narrowly stated? Should some non-medical services be covered? Should services which enhance quality of life be included as *medically necessary?* What should be done about financing technological advances which raise ethical dilemmas, create role uncertainties or build false expectations? What should the province do to reduce costs if federal policy makes this necessary?

Other challenges, some of which are discussed in ***Health Care Personnel, Hospitals*** and ***Careful Spending,*** are:

- the income aspirations of established providers
- the continuing increases in the supply of providers relative to the population
- consumer expectations
- protest over the federal government's intrusions into a field of provincial jurisdiction.

Financial Integrity

From a national perspective, the greatest challenge to the five principles of medicare appears to be the decline in federal contributions for health care. On June 12, 1990 the House of Commons passed the Government Expenditures Restraint Act, The Act, which came into effect on February 1, 1991, amends the Contributions Act and reduces federal government cash transfers to the provinces.

The federal and provincial governments have entered into an Established Programs Financing Arrangement (EPF) under the Contributions Act. But the EPF is only an informal arrangement setting out the terms by which the federal government transfers funds to the provinces under the authority of the Contributions Act. The federal and provincial governments meet once every five years to renegotiate the terms of EPF, but the federal government holds the power in this arrangement and can modify it as it sees fit.

This situation is the result of the constitutional division of power between the federal and provincial governments. The provinces have the authority to regulate health care, but the federal government is free to spend its money to influence the way the provinces act.

For the past six years, the federal government has been contributing a smaller and smaller share of the cost of BC's health care programs. Since the change to block funding in 1977, the federal cash contribution has simply become part of BC's general revenue. Depending on how much the provincial government spent and the federal government transferred, the federal share of BC costs, for health and post-secondary education has been as high as 48.4 percent in 1979/80 and as low as 39.8 percent in 1982/83. Regardless, the value of the federal government's cash transfer assigned to health compared to the province's health costs has dropped gradually and steadily since the mid-1980s.

Bill C69,
the Government
Expenditure
Restraint Act.
This odious piece
of legislation...
UNI-003

FEDERAL CASH TRANSFERS FOR HEALTH AS A PROPORTION OF THE MINISTRY OF HEALTH BUDGET: 1981/82 TO 1990/91 ($ MILLIONS)

Year	Federal Cash Transfers *	MOH Budget	Transfers as Percentage of MOH Budget (%)
1990/91	998.20	4,802.70	20.78
1989/90	1,028.30	4,383.20	23.46
1988/89	1,011.60	3,930.00	25.74
1987/88	967.60	3,650.30	26.51
1986/87	915.00	3,241.00	28.23
1985/86	865.90	2,985.80	29.00
1984/85	795.10	2,886.40	27.55
1983/84	703.00	2,769.70	25.38
1982/83	583.70	2,630.70	22.19
1981/82	522.50	2,328.00	22.44

* Value of Federal Cash Transfer allocated according to estimates of Provincial expenditures for health in $ millions ($,000,000.00)

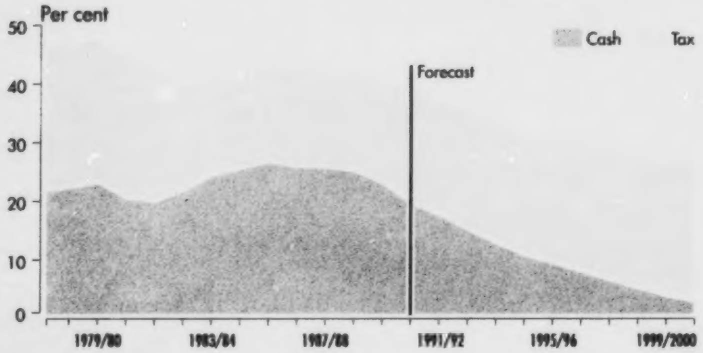
Source: Ministry of Health and Ministry of Finance and Corporate Relations.

Concerns have been raised since the introduction of the Restraint Act that these cash transfers will ultimately be eliminated, thereby releasing the provinces from the conditions set out under the Canada Health Act. Because of the different proportion of cash and tax points transferred to each of the provinces, this could happen in the very near future for some provinces (1995/96 for Quebec), while others will receive transfers well into the next century.

In February of this year, the federal government announced that it would introduce further legislation to withhold even more EPF cash from the provinces. It also announced that it would link compliance with the Canada Health Act to all federal transfers, but we are not convinced that this is constitutionally possible or acceptable.

It appears therefore that ***federal contributions for health and post-secondary education in BC will decline dramatically over the next 10 to 15 years***, and that the federal government's influence will disappear as the full effect of the Restraint Act is realized.

EPF TRANSFERS AS A PROPORTION OF BRITISH COLUMBIA HEALTH CARE AND POST SECONDARY EDUCATION COSTS



Source: 1991 Budget of the Province of British Columbia

Many people think that this could herald the end of the Canadian health care system.

The current situation was summarized in the 1990 British Columbia budget:

> *When growth in the overall EPF contribution (cash and tax) is limited to three percent points below growth in the economy (plus an amount to reflect population change), and growth in the tax point transfer component is determined by generally faster growth in income tax revenues, it is only a matter of time before cash transfers, as the residual, disappears. For British Columbia and most other provinces, this could happen as early as the first decade of the 21st century.*
>
> *Because the cash transfer is the only amount shown as an actual federal contribution in the provinces' accounts, its disappearance will have the same effect as the termination of the entire EPF arrangement.*
>
> *Long before this point, declining federal EPF cash transfers will call into question the legitimacy of a continuing federal management role in both health care and post-secondary education. A basic tenet of good public finance is that the responsibility and accountability for programs should reside with the government that raises the revenue and provides the public funds.*
>
> *Perhaps more important, a steadily declining federal contribution share will greatly aggravate the provincial problem of funding these vital social programs. This requirement will become more and more critical for provinces as their populations age - using more of the costly, high technology health care services now being developed and utilized - and as demands for advanced education grow in our increasingly competitive, technological world.*

The provincial government will not automatically be given the corresponding tax room to ensure sufficient provincial revenue to maintain the full cost of the BC health care system. This situation will result in a financial vacuum, because there is no reciprocal tax arrangement to fill the void created by the federal cash withdrawal. This problem will likely be a subject for discussions among the Ministers of Finance when establishing a new five year fiscal arrangement in 1992.

In a June 1990 report, the Standing Senate Committee on Social Affairs, Science and Technology, recommended:

that the federal government reconsider its policy of containment of EPF transfer payments with respect to hospital and medical services, and, in consultation with the provinces, seek an acceptable compromise in order to maintain a strong presence in the delivery of health care services.

Therefore, the commission recommends that:

4. the provincial government urge the federal government to

  a. repeal sections 2, 5 and 6 of the Government Expenditures Restraint Act and restate its commitment to the five principles of medicare by re-establishing the levels of funding which existed prior to the recent restraints; or

  b. give to the provinces the amount of tax room equivalent to the amount of cash transfers which will be withheld as a result of the Government Expenditures Restraint Act; and

  c. in any event, ensure that it retains the power to cause the provinces to comply with the principles of the Canada Health Act.

CAREFUL SPENDING

From the beginning of this commission we have assumed that any report calling for a major commitment of new money to the health care system would be unacceptable, and therefore unhelpful, to the people and the government of British Columbia. In 1990/91, British Columbians spent *$850,000 per hour* on health care through public and private budgets. Some new money may be available, but the principal task facing British Columbians is to find ways of making more effective use of the extensive resources now devoted to health care. To do this, it will be necessary to redirect some of these resources to the services and programs which provide the greatest benefit to the people of this province.

> *I know that the commission has heard*
> *a number of suggestions as to how to improve*
> *the health care system that would require*
> *the investment of some additional dollars,*
> *and if my perceptions are right*
> *I wouldn't be surprised*
> *if it would require doubling or tripling*
> *the health care budget.*
> HOS-040

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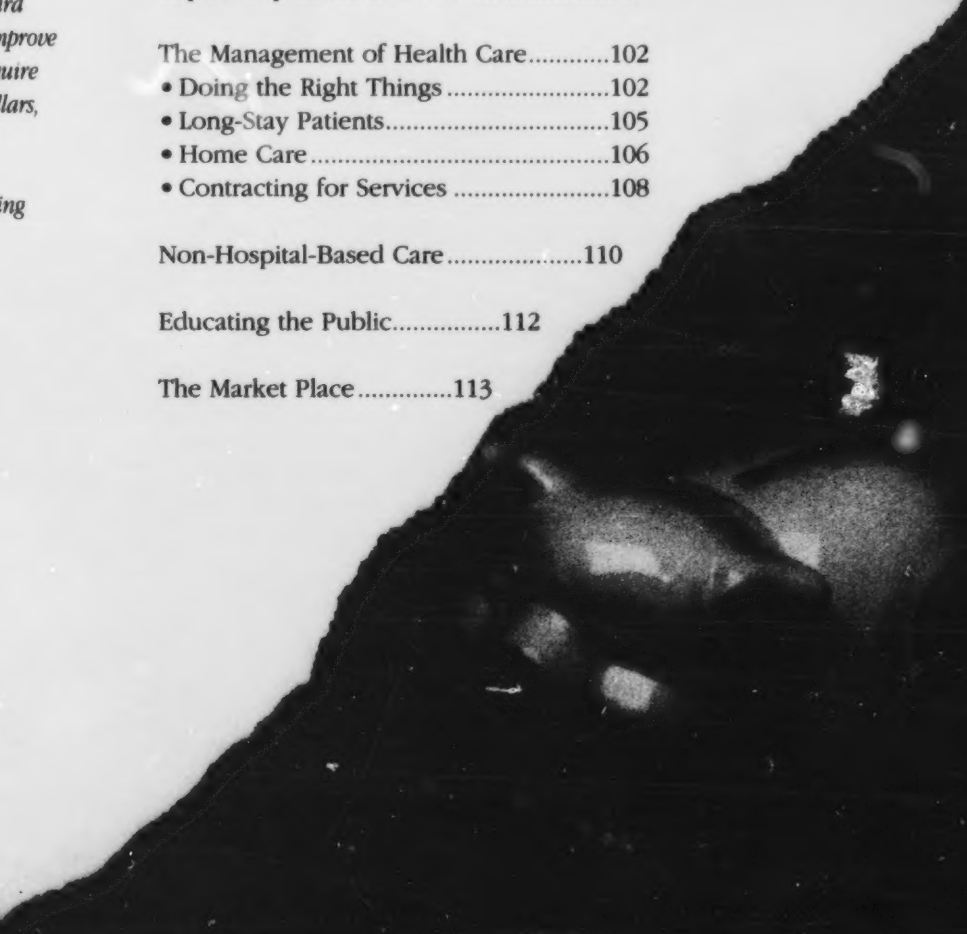


In Canada, as in most of the countries of western Europe, publicly financed health care systems were developed to improve access to care, to distribute the costs of health care more fairly, and to increase substantially the resources dedicated to health care. As these public systems expanded, however, priorities shifted, and at some time during the 1970s, most of these countries, including Canada, found ways to limit the growth of their health care systems to approximately the same rate of growth as their economies. As long as relatively rapid economic growth continued, these systems continued to grow, although less rapidly than before. One result of this growth was the expectation that expansion would and should continue.

Since the early 1980s, however, a marked slowing of general growth rates has meant that the scope for expansion of health care has almost disappeared unless resources can be taken away from other sectors of the economy. The fundamental reality of constrained resources, both public and private, is that the process of cost control has become more rigorous and contentious and the pressure of competing priorities is increasing. As far as anyone can see at the moment, these circumstances are likely to persist indefinitely.

BC has been part of this general pattern. Expanding expectations, competing priorities, and static or diminishing resources are all well represented in *submissions to the commission. But if these conflicting demands are not resolved, they might lead to the collapse, or more likely the slow disintegration, of a system of health care finance and delivery which almost all British Columbians, Canadians, and an increasing number of foreigners, regard as one of our country's finest achievements.

Some of the forces pulling at the system are obvious. Periodic debates over physicians' fees, or the wages and salaries of hospital workers, are closely linked to the overall costs of health care, because such a high proportion of health care expenditures goes directly into the incomes of health care workers.

But there are other, less obvious forces which have powerful, long-term effects on costs, and decisions which have very limited initial costs can carry a whole series of long-term implications in their train. For example, a recommendation in the mid-1960s to expand Canadian medical schools is the major factor behind the steady increase in the supply of physicians in Canada. That increase has been transmitted directly into increases in the use and cost of physicians' services, and into pressure on hospitals and other facilities. In the same way, a decision to build or renovate a hospital represents a long-term commitment of funds; the capital outlays themselves are quickly dwarfed by the cost of operating the new facility.

The extent to which policy planners and the public think through all of these implications is unclear. Often it seems that decisions just happen. Yet, years later, anyone trying to change the priorities of the system finds that the alternatives have been foreclosed, or made very expensive, difficult and time consuming. For example, a decision by the provincial government to reduce medical school positions, probably quite unpopular politically, would have no effect on health care costs for most of a decade.

Beyond capital decisions – what to build and how many people to train – administrative and professional decisions also impose long-term costs. Decisions about how to practice medicine are made by official bodies, institutions, and often by individual practitioners, with relatively little public oversight or consideration of the scale and structure of the health care system.

The commission recognizes that many of the people and groups involved in the health care system may feel that considering the cost of health care is inappropriate, or even illegitimate. But any policy which affects the proportion of the provincial resources going to health care has implications for the very survival of our health care system, and it must include cost considerations and be open to public scrutiny. In the process, a number of strongly held views about decision-making and outcomes are going to be challenged. Some of them will be rejected. There is no alternative. The trees do not grow to the sky.

Background

The health care sector in Canada has been expanding in numbers of personnel, facilities, equipment, technology, and expenditures since the end of the Second World War. From 1951 to 1971 – the period which saw the development of first private and then public health insurance – health expenditures increased approximately twice as fast as the general economy grew. By 1971 the present universal public insurance programs were essentially established "from sea to sea," and the cost of health care, public and private, took up about twice as large a share of Canadians' incomes as it had in 1951.

In the 1970s, however, the relative growth of health expenditures slowed significantly as the payment mechanisms in the public programs made possible forms of cost control which were unavailable in the previous mixed system of health care.

Ironically, and quite unexpectedly, universal coverage did not lead to an explosion of costs, but to a relatively stable, though contentious, expansion in line with Canadians' growing ability to pay. It was in the United States, which rejected universal coverage as too costly, that costs exploded. In 1971 the two countries spent very similar amounts on health care. Today, Americans spend at least one third more of their incomes on health care than Canadians and they are eyeing our system with increasing envy.

Although growth was slower and more controlled, the 1970s were still a period of expansion. It was not until the early 1980s that the combination of a major recession followed by a delayed and weak economic recovery created the present problem – how to finance health care in a low or no-growth economy.

This problem is not peculiar to Canada, or to any one province, but the 1982 recession and subsequent control measures were particularly severe in BC. In marked contrast to the two preceding decades, real income per capita has grown very little in the province since 1980. Moreover, our position relative to the rest of Canada deteriorated sharply at the beginning of the 1980s and has not recovered. Please refer to the ***Introduction*** for more information.

Initially, health care spending was completely cushioned against the effects of the recession. Government spending on health care continued to grow at traditional rates with the result that health care's share of the national income went up sharply in a very short time. But then the brakes came on, and that share more or less stabilized at its new higher level. This stability, however, is relative to a rate of economic growth which is much lower than in previous decades, and the struggle over spending has become intense. Thirty years of expansion have not brought us to the point where providers and planners agree that the service base is finally broad enough to meet society's health care needs.

The spectre
of cost-escalation
is upon us!
The affliction
of cost-containment
confronts us!
IND-340

The fact is,
that when you
get 1 in 10 workers
in our economy
working in
this industry,
all of those
who make a buck
out of it
want to expand
the size of the market.
IND-073

People in the health care field, both providers and users, believe that financial restraint has led to shortages and cutbacks in programs and services, and many submissions to the commission claim that health care deserves to "catch up" after a period of undue restraint. They describe the system as fragmented, in need of extension, expansion, and repair, and they call for additional funding, both for new and expanded programs, to meet needs and to increase the incomes and career opportunities of health care providers. Many people urge the return to what might be called *business as usual*, with continuing infusions of new resources. The expectations nurtured by three decades of growth have not been moderated by several years of restraint, nor by any recognition of the deterioration in the economy which supports health care.

The total resources for health care are not in reality being cut back. But the rate of expansion of the sector as a whole has been significantly reduced, so that new initiatives in one area must now be paid for by reductions – cutbacks – in others, rather than by adding more funds. And it is this clash, between the entrenched expectation of expansion and our present limited possibilities, which appears to lie at the root of the conflict between those who pay for and those who provide and use health services.

Health care finance is the largest expenditure item in every provincial budget, and the most complex management task faced by provincial governments. The principal burden of trying to limit the growth of the health care sector, therefore, falls to them. But the federal government also makes very large financial contributions to the provinces for health care. The essential structure of the Canadian system of hospital and medical care finance is, and always has been, provincial administration with federal financial support and general standard-setting.

Recently, however, the federal government has reacted to its own very severe debt problems by unilaterally reducing its financial transfers to the provinces. Under present legislation, described in ***Protecting the Principles of Medicare***, federal cash transfers for health care will largely disappear over the next decade. This has led to the widespread concern that medicare in Canada might, quite literally, disappear. We share this concern. Any reduction in federal contributions to the provinces will make the provincial governments' financial difficulties more severe, and increase the pressure to limit expenditures.

The decline and, perhaps, disappearance of federal support, combined with forecasts of rather weak economic growth over the next decade, mean that the prospects for a return to business as usual in the health care sector are not very bright. But because we have received so many submissions urging increased funding, we must be clear about what that would require.

Business as Usual: Expansion and Its Implications

Business as usual in the current economic environment will leave the provincial government with only three unattractive options:

- deficit financing
- increased taxation
- withdrawing resources from other public programs.

Deficit financing may be a reasonable way to fund public programs which create assets and generate income to pay the financial costs, but health care expenditure is almost entirely consumption, not investment. Deficit financing may be justified if fiscal constraints are expected to be temporary. But few in BC or Canada anticipate a return to economic growth rates similar to those before 1980. The current medium-term forecasts for the BC economy are for continued slow growth, at least into the mid-1990s, with no sharp rebound from the 1990/91 recession.

Increased taxation would require people to change their priorities and curtail their spending on other things in order to support continued growth in health care. This option is certainly possible. The rhetoric which states that Canadians are now taxed to the limit is just that, rhetoric. Other nations sustain higher rates of taxation than Canada without economic and social collapse.

However, the issue of competing priorities is real, and Canadians may well feel that they have reached the limit of what they will accept politically. It may be that tax increases directly linked to increased health spending would be politically acceptable. But views on this point are bound to differ between those who would see themselves as paying the increased taxes, those who would receive the taxes as incomes, and those whose political careers would be at risk by raising taxes.

Withdrawing resources from other programs is also an issue of priorities. In principle, the provinces could freeze all public expenditures on other programs for an extended period of time and permit a steady expansion in the share of provincial budgets devoted to health care. But those other programs include education, environmental concerns, social welfare programs, and income and housing support, all of which have a very direct effect on health. If these were cut in order to finance increased health care spending, the health of British Columbians might even be made worse. Health care is already the largest single component of provincial budgets; it is not obvious that the claims for further expansion are so compelling as to justify cutting back everything else. A return to expansion in health care is therefore possible, but it would carry a price, in terms of other priorities, which may not be acceptable to society.

In health care, as everywhere else, every dollar spent is automatically, and by definition, equal to a dollar received by someone. Therefore, any limitation on the amount of money spent must have, whatever its other effects for good or ill, a negative effect on someone's income. This means that new approaches to providing health care, with more limited expectations, will be difficult and painful.

If intense resistance by people and institutions within or outside the health care sector undermines the political support for restraint then, in the short run, one or more of these three options will have to be adopted, and the prices paid. In the longer run, the strain of competing priorities, public and private, could very well lead to the collapse of the Canadian medicare system itself.

The Fourth Option: Private Funding

Private funding represents, in a sense, a fourth option which is sometimes advocated by those for whom continued expansion in health care spending is a higher priority than the maintenance of the present public insurance systems. If public budgets are considered too strained to support a continuing expansion of the health care sector, why not draw in private funds? Various proposals range from charging user fees within the present system, through to the reintroduction of private health insurance, with or without public subsidy.

These proposals would almost certainly work as strategies for expanding health care spending. The experience of the United States indicates that mixed systems of private and public funding support a continuing expansion of the health care sector relative to the rest of the economy. The contrary notion, that private financing can *lower* overall expenditures through various types of user fees, has been disproved. Charging patients does not limit overall costs, although it does have a powerful effect on who is cared for, and how they are cared for. The deterrent effect is greatest for lower income people. This point deserves careful consideration, since intuition, experience, and experiment all demonstrate that, at least for outpatient services, user fees do influence people's decisions to seek care. It seems obvious that if people go less often to health care providers, the use and costs of care will be lower. But this assumes that the patterns of use of those who do seek care will not change in the opposite direction.

If the providers of care are able to influence the care received, as physicians can, and if they offer more care – more procedures, more interventions – when they have the time to provide it, the total amount of use need not fall. User fees for patient-initiated outpatient care may deter people from seeking care, but there is no evidence, in Canada or elsewhere, that they affect the total use of medical or hospital care. The United States' experience in particular, with very high user charges to patients and rapidly increasing costs, shows their lack of effect.

Controlling costs has been impossible in the American system, and the different payers for health care have reacted with increasingly strenuous efforts to shift costs from their shoulders to someone else's. In contrast, the nations of western Europe which have, like Canada, been relatively successful in containing cost expansion, have done so through legislative and administrative controls imposed on a public payment system, and not through the expansion of private payments.

This fourth option, private funding, has some other very unattractive features, which is why increasing numbers of Americans are advocating the adoption of a universal public insurance system similar to that in effect in Canada.

First, more money spent on health care must mean less spent on something else, whether the additional money is raised from public or from private funds. As the Royal Commission on Taxation pointed out some years ago, 'a buck is a buck is a buck' no matter which channel it flows through. Private financing forces the users of care (or the payers of premiums) to give up other things, to reduce their other spending or their savings. Public financing imposes the costs on taxpayers.

The difference is that public spending distributes the burden of *other things given up* over the whole society, in proportion to the taxes people pay. And taxes are generally related to people's ability to pay, as reflected in their income, spending or assets. Private finance distributes the burden according to the amount of care that a person actually uses (user charges) or according to an insurer's estimate of how much that person is likely to use (private insurance premiums). Critics of private finance say that private funding "taxes the sick". As a way of expanding health care spending, it is no less painful than public funding, but the pain is borne by different people.

Second, the American experience makes it clear that private funding, at least through the private insurance mechanism, is far less efficient than public funding. A much higher, and rapidly growing, proportion of spending goes to pay for the administrative costs of the funding system. The most recent estimate of the amount by which American administrative costs exceed those in a Canadian-style system, is between $90 and $120 billion US.

Third, as private funding sources become a significant proportion of health expenditure, people with lower incomes and at higher risk of health expenditure (the two are correlated) are excluded from care. The extraordinary number of Americans who are either underinsured or uninsured – between 30 and 50 million – is notorious world-wide.

But this is simply the natural and inevitable outcome of a competitive private insurance market. To survive, private insurers seek out and cover the healthy and the wealthy. They shun the poor and sick not because they are malicious, but because in a competitive market they have no choice. This does not mean that the uninsured are deprived of all services. But they do have significantly less access to care than the rest of the population. This process of exclusion was already underway in Canada in the early 1960s, when the federal Royal Commission on Health Services (Hall Commission, 1964) rejected the private insurance industry's proposals for a mixed funding system.

Finally, a nominally private system still requires a large public component because the people with the greatest health problems – the elderly, the poor, those with certain chronic illnesses – must be covered by public programs. Private insurers cover only the better risks, and even then, only with substantial public subsidies through the tax system.

A small-scale private sector like that in the United Kingdom, which allows the well-off to buy their way to the head of the queue, and then be cared for with public funds, will always be popular both with those who have the extra resources (and no serious illnesses), and with those who control the queues and directly or indirectly pocket the payments. But it cannot generate enough resources to have a significant effect on the public funding problem.

Private funding is a popular 'quack' remedy with dangerous ingredients which will defeat, not support, the objective of controlling costs. ***The harm it could bring is one of the strongest pressures forcing Canadians to find better ways to manage the present system, and, therefore, preserve it.***

Privatization

Private funding is not the same as privatization, which is a more complex concept with several different meanings in the health care field. These meanings are often confused in the heat of debate.

At one end of the spectrum, privatization refers to private insurance or user-pay systems in which people can buy the 'best' physicians and hospitals with their own resources, or buy their way to the head of a queue. People with great needs and small resources can have whatever is left over – eventually. We believe that the people of BC, and of Canada, have made it clear that this is not acceptable, and it is not acceptable to this commission.

At the other end of the spectrum, however, no one appears to be concerned if a hospital patient rents a television set or pays extra (the Preferred Accommodation Differential) for a private or semi-private room. The financial transaction involves the patient directly, but it is for a service which is quite separate from the patient's medical needs.

A similar example is provided by the room and board charge in *long term care facilities: the facility is the patient's home and people who are not in an institution also pay for their room and board. This principle does not apply in *acute care hospitals because patients are still maintaining homes elsewhere. However, if one combined the Preferred Accommodation Differential with the room and board charge in long term care, it would seem acceptable to provide different standards of long term care at different levels of charges.

We encourage you not to forget the health system as an engine of the economy in the manner of other government expenditures.
HOS-035

The commission supports this type of privatization in principle, although we recognize that there are some problems in practice. For example, it would not be acceptable for a hospital operating at a very high occupancy rate to convert a large proportion of its facilities to private rooms, and then refuse to admit patients who did not wish to pay the Preferred Accommodation Differential.

The overriding consideration in all such cases must be that when extra services or choices are made available to those who pay for them, there must be no disadvantage imposed on those who do not. Standard care must not be withdrawn or degraded in order to push people into paying for premium accommodation.

Both of the examples given are of financial transactions involving the patient, but privatization may also relate to the provision of medical services which do not involve the patient at all. For example, the Saskatchewan Pharmacare program purchases drugs on competitive tender from commercial suppliers just as a private corporation would. We think that this is an appropriate form of privatization for a range of medical services; the buyers might be the Ministry of Health, a hospital, or a regional board.

The American experience has shown the potential for inefficiency, inequity, and uncontrollable cost escalation with private funding systems. But public systems can also be inflexible, inefficient, and unresponsive to the people they serve, and end up serving the people who work in them. Private systems can create user-friendly environments that are very responsive and provide a wide range of choices, but only for those who can pay. Where mechanisms similar to those in the private marketplace which encourage responsiveness and efficiency can be developed, they should clearly be encouraged.

Health Care Expenditures in BC

Total health care spending in BC in fiscal year 1990/91 was approximately $7.25 billion or about $2300 for every person in the province. Seventy percent of this, $5.05 billion or about $1600 per person, was spent by the provincial government, almost all of it through the Ministry of Health which spent $4.8 billion. Most of the remainder, just over 25 percent, was spent by individuals, with or without private insurance reimbursement, and primarily on dentistry, drugs, eyeglasses, and a portion of long term care services. A small amount of direct expenditure by the federal and municipal governments, and by the Workers' Compensation Board, completes the total.

The provincial budget estimates that health care spending will rise by 8.7 percent to $5.49 billion for 1991/92, which would make the per capita level about $1700. Adjusted for inflation, this represents a budgeted increase of about one percent. It should be noted that the actual increases of recent years have been substantially greater than this.

Expenditures on hospitals and physicians' services are almost entirely paid through the provincial Ministry of Health; only about 5 percent of these items come from private sources. Correspondingly, they make up the largest share of the provincial expenditures and, therefore, are the major focus of this chapter. Roughly one-half of ministry outlays are for Hospital Care programs, another quarter goes to the Medical Services Plan (MSP), and another 10 percent to *Continuing Care, accounting for 85 percent of Ministry spending and just under 60 percent of all health spending in the province. The provincial Pharmacare program, which represents about 5 percent of Ministry spending, is discussed in ***Prescription Drugs.***

MINISTRY OF HEALTH EXPENDITURES, 1990/91
(estimated)

PROGRAM	FUNDING ($million)
Hospital Care programs	$ 2,372.0
Medical Services Plan	$ 1,211.7
Continuing Care	$ 494.0
All other programs	$ 732.0
TOTAL EXPENDITURES	$ 4,809.7

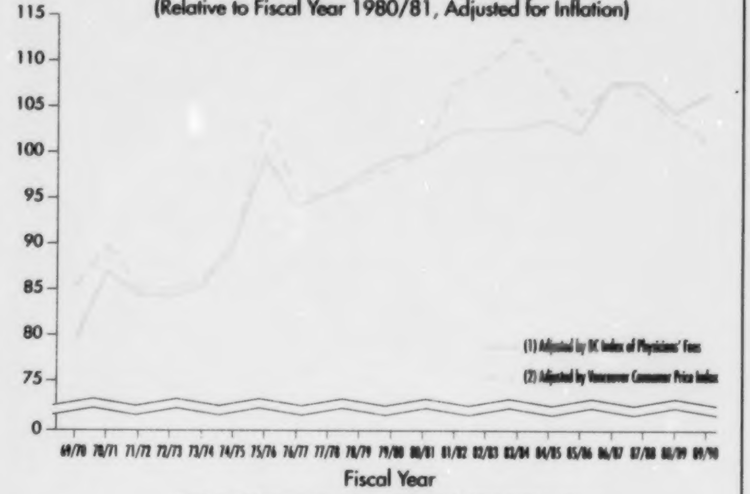
Ministry of Health Estimates 1991

Physicians' Services

Understanding the cost of physicians' services in BC is, at an abstract level, a simple issue. MSP expenditures equal the number of physicians in practice, multiplied by the average gross billings per physician. A great deal more detail can be added about full and part time status, other forms of payment, other sources of payment and so on, but these do not change the major variables of this equation.

* GLOSSARY

FIGURE 1
AVERAGE GROSS PAYMENTS PER PHYSICIAN
BY BC MEDICAL SERVICES PLAN
(Relative to Fiscal Year 1980/81, Adjusted for Inflation)

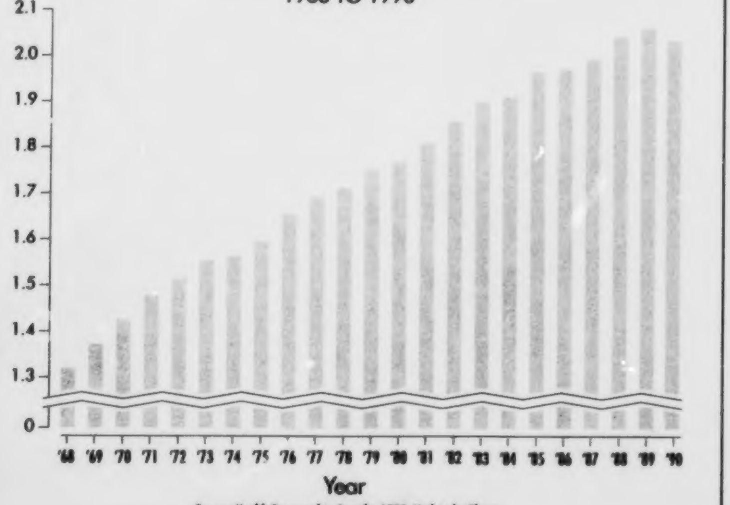


Data do not include retroactive payments for 1989/90 provided for in 1991 fee settlement:
these will increase the 89/90 payments by about 4%

Today's problems come from yesterday's solutions.
MUN-020

Between 1969/70 and 1989/90 the total amount spent by MSP on physicians' services rose by nine times. However, this spectacular increase had little or nothing to do with health care. General inflation, the overall increase in prices, wages and incomes, means that, on average, everyone has more money but cannot necessarily buy more things because everything costs more. The cost trends for physicians' services, therefore, should be measured relative to general inflation, which the commission has done by using Statistics Canada's Consumer Price Index (see figure 1). Once adjusted for inflation, it is clear that physicians' fees in BC have not independently contributed to increasing costs.

FIGURE 2
NUMBER OF BC PHYSICIANS PER 1,000 PEOPLE
(Exclusive of Residents and Interns)
1968 TO 1990



Source: Health Personnel in Canada, 1989: Update by Phone

Yet, expenditures, adjusted for inflation, have more than doubled in the same period. This is because of increases in:

- the number of physicians
- the population
- the use of physicians' services.

The greatest increase has been in the number of physicians per capita in BC, which has grown by nearly 50 percent since 1969 (see figure 2). This has not meant less work for each physician. On the contrary, payments to physicians, adjusted for inflation, have risen by nearly 20 percent in the last two decades.

To date, there has been no agreement – nationally or internationally – on the appropriate number of physicians required to meet the needs of a given population. The most that has been done is to speculate that some number larger than the present number would probably be adequate. But each time this adequate number has been approached or reached, it has been revised upward again. Many students of health care personnel planning now believe that no best number exists, and that the real question is rather, how many physicians does a population want to support?

The critical document in establishing the supply of physicians in Canada was the Report of the Royal Commission on Health Services (Hall Commission, 1964). In reviewing past and projected trends in population growth and the historic physician supply, and in responding to representations from a number of professional groups, Justice Emmett Hall determined that a serious shortage of physicians was looming, and that "the problem of providing sufficient medical school facilities... requires *immediate* attention." [emphasis in original]. Justice Hall therefore recommended the expansion of Canada's existing medical schools, and the establishment of five more. His recommendation was largely carried out.

Justice Hall's explicit target was the maintenance of the 1961 ratio of 857 people for each physician, which he considered to be "more realistic" than continuing the rate of increase in the number of physicians relative to the population which had occurred between 1951 and 1961. According to Hall's projections, this historic rate of increase would have resulted in a ratio of 665 people per physician by 1991. Yet, by 1990 the actual number of people per physician in Canada was 452, and BC just equalled the Canadian average.[1] Hall's policies have led to almost twice as many physicians relative to the population as he had contemplated. What went wrong? Almost everything.

Quite unexpectedly, the report was followed by the most dramatic decline in fertility rates in Canadian history. Instead of increasing as projected, the absolute number of births fell, with the cumulative effect that the population in Canada in 1991 is ten million people *fewer* than Hall projected.

Also, physicians did not abandon the country in large numbers in response to socialized medicine. In fact, the number of physicians immigrating to Canada increased sharply in the late 1960s and early 1970s, to the point that in some years it exceeded domestic production. By 1975, the cumulative effect of this influx was so large that the federal government removed medicine from the list of priority occupations for immigration, and began to discourage would-be physician immigrants.

Moreover, Justice Hall's anticipated increase in demand for, or at least use of, physicians' services in response to the public plans did not materialize. While public insurance changed the distribution of services in the population – more for lower income people, less for higher income people – it did not lead to an explosion in use.

It was evident as early as 1970 that the Royal Commission on Health Services' projections were very badly in error. But the policy responses to shortages and surpluses are very different. Those who gain from institutional expansion, and lose from contraction, are self-aware, articulate, and well organized, so the increases which Hall called for took place. The burdens of increasing supply, on the other hand, cumulate over long periods of time and are diffused over the whole population. Therefore, even when it was very clear that the projections were wrong and the "supertanker" of provincial and medical school commitments could not easily be turned around, no changes were made in the policy of expansion. The policy failures of the early 1970s are now the cost problems of the 1990s.

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[1] For comparability with Hall's data, these numbers include interns and residents as physicians. Since they are paid salaries by hospitals, interns and residents are excluded from the numbers of BC physicians compared with MSP outlays. Their exclusion yields the figure of 492 people per physician.

It is important to be clear as to what the data say, and do not say. Some have interpreted them as 'blaming' physicians, individually or collectively, for the current rates of cost increase. Physicians, in particular, react with understandable distress to what they perceive as an implication of inappropriate servicing, or even unethical conduct, to maintain their incomes. Some argue instead that the increases in use are caused by rising public expectations, overstimulated by governments – "not our fault but yours." Moreover, they claim that the increases in use correspond to "better medical care", and point out that many problems and illnesses are now treatable which were previously beyond the reach of medical practice.

But data, by themselves, are just data and carry no implication of praise or blame. The facts are that a population forecast was made in the early 1960s which turned out to be wrong. The error was obvious by the early 1970s, but the personnel policies based on it have never been changed. The result is that there has been a large increase in physician supply relative to the population.

Logically, this increase must have one of two possible effects (or a combination). Either average physician workloads must fall, or total use must rise in proportion to the increase in supply of physicians. If fees do not change, then either average physician incomes must fall or total expenditures must rise. What the data tell us are that average physician workloads did not fall as the supply increased – indeed they went up somewhat – and therefore total expenditures increased with the increase in supply.

Whether one celebrates a correspc ing increase in the quality of care, deplores an increase in unnecessary servi ing, is irrelevant to this calculation. Th commission does neither.

For many years, BC had more physicians per capita than the national average – in 1968 there were 756 people per physician in BC compared with the national average of 909 – but this pattern has been slowly changing, and by 1990 the differential had almost disappeared. Even more interesting, data for the end of 1990 indicate that for the first time in 40 years in both BC and Canada, the increase in physician supply did not outstrip the growth of the population.

Why this has occurred is unclear. It might be the result of several years of fee freezes, caps on payments for increased use, attempts to limit billing numbers and hospital privileges, and a generally tough – some might say confrontational – negotiating stance by the provincial Ministry of Health. But the halt in overall physician supply increase has no immediate explanation, since there has been no significant change in the numbers of new graduates, or, as far as is known, migration patterns. If it persists, then an extremely important component in the cost of health care has changed significantly, and in such a way as to ease overall cost pressures.

In any case, it is important in the longer run that the government of BC work with other provincial governments to ensure a growth in physician supply which is consistent with the needs of the Canadian population and with the growth in its economic resources. This is addressed in more detail in ***Health Care Personnel***.

The cost implications of a continuation of past trends are substantial. Between 1968 and 1990, the number of people per physician in BC fell from 756 to 492. If this trend were to continue, we would reach a ratio of 397 people per physician by 2001. In today's terms, this alone would add about $300 million to the costs of health care, even if there were no increases in the population, price levels, or the relative incomes of physicians. If gross receipts rise, the cost implications of increased supply will be even larger. Increases in physicians' services also place pressure on hospital facilities and diagnostic services, and can increase the prescribing of drugs.

To date, the provinces have been unable to regulate the number of physicians with access to medical service plans. For example, BC's attempt to control the number of billing numbers did not withstand a court challenge. The only other approach to cost control, therefore, is to place an absolute cap on the total amount of money available for payment of physician services.

In their debates, the commissioners expressed a strong preference for a "hard cap" that does not include adjustment factors which, while in principle capable of affecting the described use of physician services in either direction, in practice serve as justifications for raising the cap. If there are specific changes in medical technology or in the needs of the population which can be clearly identified and approximately costed, they should be discussed at the bargaining table. But it must be emphasized that these changes must be able to move the cap either way. A development which reduces the time and effort required to perform a procedure, or a fall in the prevalence of an illness (for example, through immunization) are grounds for lowering the cap, just as a new disease or procedure might raise it.

The agreement negotiated between the BC Medical Association (BCMA) and the provincial government for the period April 1, 1989 to March 31, 1992 provides a very loose cap – looser than previous contracts in BC. The proportion of increases in service use, for reasons other than population increase, which are paid to physicians, varies depending upon the extent of the increase. But with very few exceptions, either half or all of any increase will be paid. A ***hard cap*** means that ***increases in use above those resulting from population change do not result in increases in payments to physicians.***

We are also concerned that current and past negotiations appear to allow increases in the costs and use of physician services above the capped level to become part of the established cost base in subsequent negotiations. The penalty for exceeding the cap – that physicians have to return some proportion of their excess receipts – is in fact only a partial, one-time repayment.

There can be some flexibility within a hard cap. For example, it might be made up of component caps, which cap the total billings for a region or a specialty. It might also place limits on total billings by individual physicians, per quarter, per day, or other time period. Such individual limits, already under discussion in other provinces, might contribute to improved quality of care by discouraging levels of activity which raise questions about appropriateness and the amount of time taken per patient. They would also ease the unfairness of an agreement under which the rapid rise of one physician's billings imposes cuts on more conservative, and perhaps more efficient, colleagues.

A structure of this type could also be used to promote other objectives, such as the redistribution of physicians among regions or specialties discussed in ***Health Care Personnel***. A structure of multiple, linked caps could then be part, but only a part, of a more general set of policies to improve the health care system. But, for the purposes of cost control, all of these flexible components must be contained within an overall limit on total payments to physicians. If, as the most recent data suggest, the rate of increase in physician supply has moderated, and if that represents a permanent change in the trend, then a hard cap based on population and general inflation should still be imposed. In fact, it should become significantly easier to maintain.

We recognize that physicians in BC may be distressed by this recommendation. But measures to place limits on the expansion of the health care system are, in the long run, in the interests of the public, the medical profession and individual physicians as well. If generally satisfactory ways can be found to manage the number of physicians practising in BC, the cap may become superfluous. But, if this major cost component continues to grow more rapidly than the economic base which supports it, we do not believe that the health care system will survive in its present form.

Therefore, the commission recommends that:

1. **there be an annual global cap on the gross payments to physicians by the Medical Services Plan. This cap should be adjusted for changes in population and in the general price level, but should not respond to increases in utilization, or be adjusted for changes in "technology" or other essentially unquantifiable factors.**

The commission received a number of submissions suggesting that suitably trained nurses should be substituted for general practitioners. *Nurse practitioners require less extensive training than general practitioners, because they deal with a more limited range of problems, and where they are used, receive lower incomes than physicians. This substitution would, therefore, lower the costs of health care.

This idea is quite contentious. Although physicians tend to reject such claims with vigour, there is a substantial body of evidence which demonstrates that nurse practitioners can in fact provide a significant portion of the services of general practitioners, and some specialists, to the same quality standards and at a lower cost. Nevertheless, we cannot recommend the training or hiring of nurse practitioners as part of a strategy for containment of costs.

The reason is quite simple. If we are to *lower* costs by substituting nurse practitioners for physicians, we would have to reduce the amount paid to physicians by more than the amount paid to the nurse practitioners. We anticipate that limiting the total payments to physicians to a capped amount will be difficult enough without further reducing that amount to provide for nurse practitioners. Having trained more physicians than we wish to pay for, we cannot now create and pay for still another source of medical services – or at least, not if we want to control costs.

Hospital Care – Labour Costs

Health care is labour intensive. A rough rule of thumb for acute care hospitals is that 75 cents of every dollar spent goes directly to paying people, in the form of wages, salaries, fees, and other benefits. The remaining 25 cents is then used to buy medical supplies and drugs, other supplies and food, to support capital programs and purchase equipment. The proportion of money spent on wages is even higher for chronic care hospitals and nursing homes, estimated at 80 cents on the dollar.

Of payments to physicians, dentists, or other professionals, between 60 to 70 percent represents their net incomes, while a significant share of the remaining "practice overhead" is made up of wages and other benefits of employed support staff. Even expenditures for drugs have a direct labour component. The incomes of pharmacists and support staff come from the dispensing fee. As a consequence, the issues of wage and benefit rates and staffing patterns are central to any understanding of health care costs. An examination of trends and patterns in labour costs in BC since the introduction of medicare in 1968, is therefore, essential.[2] Of the estimated $1600 spent by each British Columbian through the Provincial Government in 1990/91, approximately:

- $800 was spent on hospitals
- $400 was spent on physicians' services
- $160 was spent on continuing care.

Of the $960 (about $1,000 in 1991/92) spent for hospital and continuing care, about $740 was for wages and benefits. As nursing departments account for just under half of all paid hours for hospital workers, nursing staff receive almost 40 cents of every hospital dollar.

These outlays were the result of a process of wage negotiations and staffing decisions which has gone on since the introduction of medicare, and before. The trends since 1969 are of particular interest, however, because the institutional framework of reimbursement for hospital and medical services took on its present form at that point, and because some of the data series date from then.

As noted at the beginning of this chapter, overall economic activity in BC proceeded quite rapidly in the 1970s, at rates similar to the previous two decades. The 1980s, however, began and ended in a recession, with only a weak recovery in between. After adjusting for inflation, output per capita was not much higher at the end of the decade than at the beginning. Average weekly earnings (industrial composite) actually fell, relative to inflation, between 1980 and 1990.

But the lean years did not entirely eat up the fat years and over the whole period. British Columbians, on average, have become better off in economic terms. While the general consumer price level nearly quadrupled from 1969 to 1990, the average weekly earnings rose by about 17 percent in *real* terms.

The bitter reality for nurses is, that every time we are able to negotiate a significant wage increase, it is usually a catch-up increase.
UNI-013

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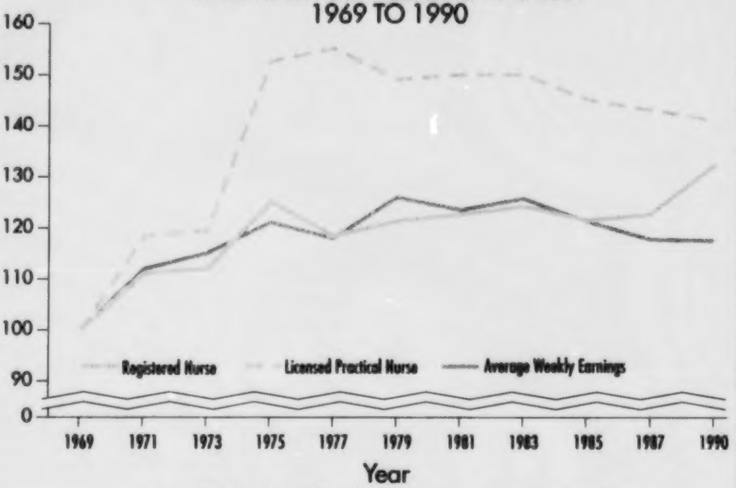
[2] Of course, as noted above, 100% of all expenditures must go, by accounting definition, to someone's income. But the earner need not receive wages, or be in the health care field. A part of drug expenses, for example, is eventually paid to shareholders of drug and supply companies and others not generally considered to be part of the health care system.

FIGURE 3
RELATIVE SALARY INCREASE (CONSTANT $) FOR REGISTERED NURSES, LICENSED PRACTICAL NURSES AND AVERAGE WEEKLY EARNINGS: 1969 TO 1990

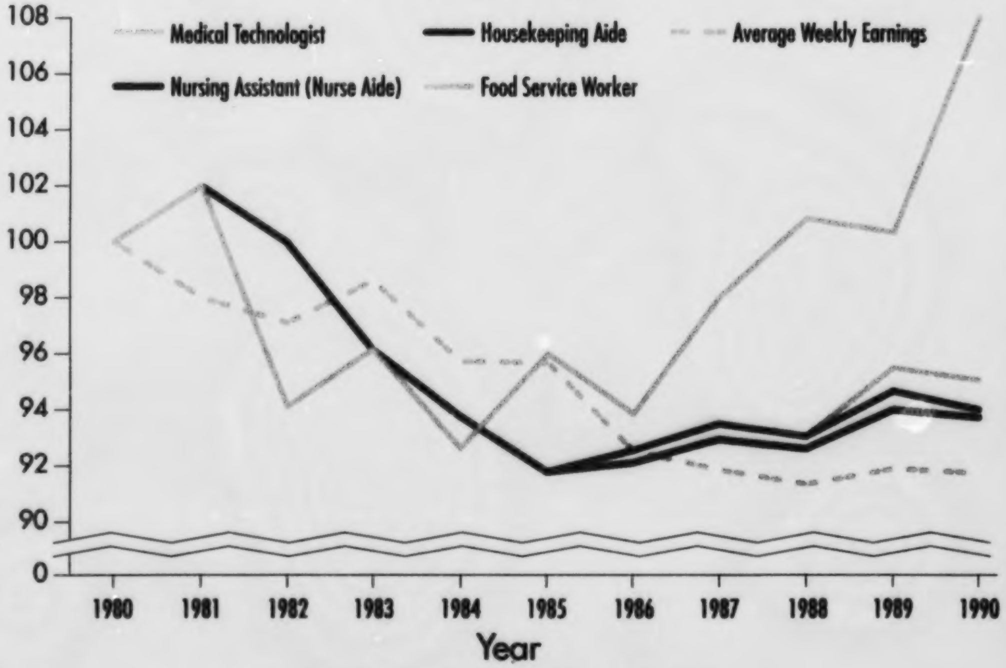


Source: HLRA: Wage Relationships of LPN to RN - (monthly salary), File No: C073-024

Wages for hospital workers, however, have outpaced the general wage level since 1969. And although the 1980s were a bad decade for most of the province, hospital workers still gained a little ground.

- Registered nurses' (RNs) incomes were up 32 percent over 1969, nearly twice the general increase for the province.
- Licensed Practical Nurses (LPNs) caught up a significant part of the differential between themselves and RNs during the 1970s, only to have that gap widen again in the 1980s. Taking the period as a whole, however, their wages rose somewhat more than those of RNs.
- Nurses' aides, housekeeping aides and food service workers appear to have suffered a fall in real wages during the 1980s, though not as large as the decline in Average Weekly Earnings for all of BC.

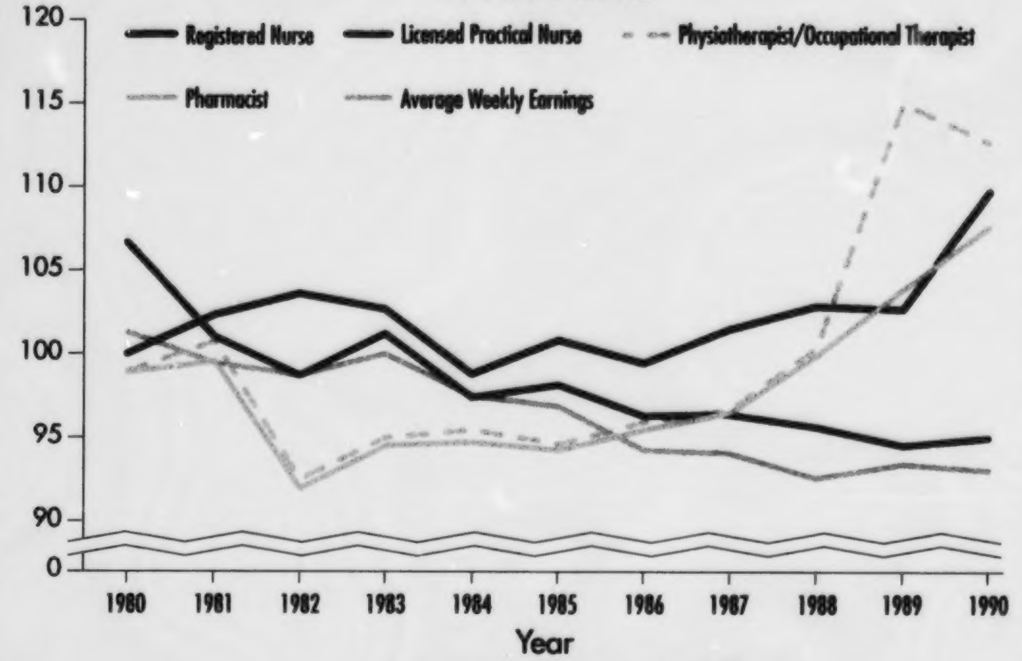
FIGURE 4
RELATIVE SALARY INCREASE (CONSTANT $) FOR SELECT HEALTH CARE WORKERS AND AVERAGE WEEKLY EARNINGS: 1980 TO 1990



Source: Collective Agreements, HLRA/HSA Comparison of Monthly Wage Rates of Minimum and Maximum Levels: HLRA; Feb, 1991

FIGURE 5

RELATIVE SALARY INCREASE (CONSTANT $) FOR SELECT WORKERS AND AVERAGE WEEKLY EARNINGS: 1980 TO 1990



Source: HLRA: File No: C023-24 Collective Agreements, HLRA/HSA Comparison of Monthly Wage Rates of Minimum and Maximum Levels.

- Physiotherapists, occupational therapists and medical technologists have all done well in recent years.

These gains have not been uniform over the 20-year period. For example, nurses' wages have tended to move ahead of the general wage level and then fall back to the overall trend. Their real wages have held up during the 1980s, however, and a gap has opened up again (see figure 3).

Such trends do not, of course, tell us whether nurses' or other hospital workers' wages are too high or too low. It can be argued – and usually is, in the collective bargaining process – that hospital workers were underpaid in the 1960s and deserved to catch up. It might also be argued that wages in hospitals compare very favourably with those in similar occupations elsewhere. But perhaps they are also underpaid.

What the trends do show is that a part of the escalation in hospital costs in the last 20 years resulted from rises in the wages of hospital workers, relative to average wages in the rest of BC (see figures 4 & 5). Since hospital and continuing care wages cost each British Columbian roughly $740, a relative increase of 15 percent would account for about $100. This amounts to an annual cost of about $300 million for the province as a whole, to finance the gain in wages for hospital workers relative to the provincial community.

There are more LPNs being laid off in Castlegar, in Victoria. We fail to see where it is making economic sense. We really do. At a time when they are crying that they are short of dollars for health care, why not utilize those dollars? Why not get the most possible from those dollars?

UNI-095

This is not a trivial sum. But it is only one component of the overall increase. From 1969 to 1990/91, total expenditures on hospitals rose by nearly 15 times. Adjusting for inflation and population growth eliminates most of this apparently spectacular growth, but hospital spending in 1990/91, in real terms and for each person, was still two-and-a-half times its 1969 level.

Inpatient days for each person in BC rose relatively little over this period – less than 1 percent per year. Other components of hospital workloads, such as day care surgery, have risen more rapidly, but adjusting for these activities does not change the general result. Hospital expenditure per person, in inflation-adjusted dollars – largely unrelated to any increase in patient day load – has been rising at an average annual rate of 4.5 percent for more than two decades.

Continuing at this rate for another decade will add about $1.5 billion to provincial health care expenditures by 2001/02. If the population grows at its current rate of 2 percent per year, the additional spending would be nearly $2 billion in today's dollars.

Increases in personnel costs have been the largest component of this trend. From 1969 to 1990/91, wages and benefits to hospital workers rose, in real terms, at an annual rate of about 4.75 percent. This is faster than can be accounted for by increases in hourly wage rates or patient-day loads.

Patient-days are not an adequate measure of the real workload of a hospital. It is often argued that the patients in hospitals are more acutely ill now than in the past. Certainly patients now receive, in the course of a day, a much greater, more sophisticated, and more expensive array of direct and indirect services, from more people, than they did 20 years ago. But, explanations of increased costs in terms of increased intensity of servicing tend to be descriptions of what was done – accounting explanations – rather than justifications of why, or with what result.

Whatever the source of this growth in costs, ***if the BC health care system is to survive and adapt to new priorities and needs, this pattern of growth cannot continue***. As in the case of physician supply, no major component of the health care system can grow indefinitely at a rate well above that of the general economy that supports it.

We have not done a complete accounting for the hospital sector in BC, nor to our knowledge has anyone else. But logically, the sources of past (and future) increases in labour costs that are in addition to increases in hourly wage rates, must fall into a small number of specific categories:

- fringe benefit costs per hour worked
- job classification of hours worked
- hours worked per patient-day.

Wage increases referred to above are based on wages per paid hour. But some fringe benefits, such as paid sick leave, take the form of paid hours in addition to time actually worked. Therefore, any increase in cost, or earnings, for each hour worked is a combination of the increase in the wage rate for each hour *plus* the negotiated increase or decrease in the number of paid hours for each hour worked.

Changes in the job classification of workers also affect costs. For example, since registered nurses (RNs) earn more per hour than licensed practical nurses (LPNs), a shift from LPN to RN staff will raise costs for each hour worked, simply because higher cost hours are being substituted for lower cost hours. More generally, increases in the average skill or qualification level of the hospital labour force which result in increased rates of remuneration will contribute to higher labour costs.

Finally, the total number of hours worked by all types of personnel may go up or down. More highly skilled workers, for example, might be able to get the same work done with fewer hours. As discussed in ***Hospitals*** and ***Health Care Personnel,*** advocates of all-RN staffing for hospital wards – the primary nursing care model – sometimes argue that although RNs cost more per hour than LPNs, they are more efficient and, therefore, overall costs do not rise. This could occur, if overall hours of care per patient-day fell with increased RN staffing, or if such staffing led to a reduced use of hospitals through, for example, earlier discharge or reduced readmission rates. But this has not been the trend in the past. Instead, the hours worked for each patient-day tend to increase over time.

Some combination of these components of labour costs, along with increases in wage rates, accounted for the past increase in expenditures. Moreover, a large number of the submissions we received from hospital personnel recommend further increases in one or more of these components. For example, nurses who are concerned that they have to perform "non-nursing duties" recommend increases in hospital budgets to hire other staff, but do not recommend decreases in nursing staff. They also request the privilege of early retirement at full pension, which would result in a substantial increase in paid hours for each hour worked, in order to meet increases in the costs of their pensions. They also recommend the establishment of a BScN as the minimum qualification for entry to nursing. This would either lead to increased costs for each hour worked to pay for the increased qualification, or to substantial dissatisfaction among a workforce with higher qualifications but without higher pay.

But nurses were not the only hospital workers that asked us to support these types of increases. We received a number of submissions calling for:

- more staff opportunities for subsidized education, either in-service or on leave, again representing more paid hours for each hour worked
- the Ministry of Health to "recognize" increased severity of patient illnesses as reflected in workload measurement systems, representing requests for more staff hours per patient-day.

All of these increases are over and above any of the consequences of collective bargaining over hourly wage rates. They are also additional to any expansion in hospital-based programs. Taken in total, these submissions are calling for a substantial expansion in funding for the hospital sector, which is, of course, consistent with the historical pattern. Government policies of restraint, which have been associated with lower rates of expenditure growth in the last few years, have been criticized as cutbacks in a number of submissions which call for a return to more rapid increases in funding – for a return to "business as usual."

Yet an equally consistent theme in submissions to the commission, and one which we support, is the need to move health care services and resources out of institutions and into homes and home communities. In fact, these two basic ideas – less reliance on acute care hospitals and a reallocation of existing resources – characterize health care reform proposals throughout the industrialized world.

Any time we want to know what the cost is to treat a particular condition, we have to go back to first principles and start again, because there are no standardized consistent protocols for estimating the costs of treating particular patients in institutions.
Research Forum

These reforms are based upon the principle that, as the care workload moves from one site to another, the resources that support it must move with it. If, as the commission assumes, large amounts of new money are not likely to be made available for the health care sector, then it becomes obvious that this reform will require shrinking the resources available to the acute care hospital sector. Any further improvements in the earnings, benefits, and working conditions of hospital workers must, therefore, be made in the context of not only constant but lower overall hospital budgets. This can be achieved by a combination of increased productivity for each hour worked and, probably more importantly, very significant reductions in the amount of care provided in hospitals. We are persuaded that this can be done, and done not only without risk to patients, but with benefit.

As discussed in ***Hospitals***, there is a substantial proportion of inappropriate care provided in BC hospitals. Analysis contracted for by the commission indicates that about 25 percent of the acute care days provided in 1989/90 in BC could have been provided in other facilities or through other programs, or were not needed at all. At an occupancy rate of 80 percent, these unnecessary acute care days required about 3000 acute care beds – over half the beds in the Greater Vancouver Regional Hospital District (GVRHD).

This analysis addressed only the question of whether the patients admitted in 1989/90 might have stayed for a shorter length of time, or have been cared for as day surgical or day medical patients. It did not consider whether treatment should have occurred at all. Yet widespread evidence, nationally and internationally, of significant variations in patterns of medical and surgical practice in apparently similar populations has made this a major issue in health care. If this experience extends to BC, and some submissions suggest it does, then it is a source of grave concern, and an additional potential source of savings in hospital costs.

There is no doubt that similar institutions care for patients with similar problems in quite different ways. As well, most hospitals in BC appear to have little or no idea what it costs them to perform particular procedures or resolve particular patients' problems, much less how their costs compare with those of other hospitals. If hospitals do not routinely evaluate and compare the effectiveness of their practices, it is unlikely that they will have exploited all or even most of the opportunities for improved efficiency. This leads us to believe that a much more careful examination of internal practices, described more fully in ***The Best Care,*** could mean significant reductions in costs.

More effective management of the very expensive provincial resources represented by acute care hospitals, can free up funds for continuing care and for other needed health care programs. But it must be understood – and this cannot be avoided – ***such an approach implies fewer jobs in hospitals***. Furthermore, since a primary motivation for reducing the size of hospitals is to transfer resources to other health care programs, it would be highly inappropriate for all the savings won through this downsizing to be absorbed in improvements in the relative earnings, benefits, and working conditions of hospital workers.

Therefore, the commission recommends that:

2. **total funding for hospitals and continuing care be capped in the same way as payments to physicians, with the cap adjusted for changes in population and the general price level.**

3. **funds be transferred, over time, from the acute care hospital sector to continuing care, including both *home care and other forms of less intensive institutional and residential care.**
4. **there be adopted, through the decade of the 1990s, a strategy to maintain equality between the wages and benefits of health care workers and the general wage level in the British Columbia economy.**

The commission has not recommended a specific link between hospital and private sector wages, for two reasons.

- For some types of personnel, BC hospitals are part of a national and international market, and the wage structure cannot depart too far from wage structures in other jurisdictions.
- The real concern should be with wage costs, not wage levels.

If, by improving management and changing work patterns, a hospital improves productivity and provides the same or better care, then it should be possible to share some of this gain with workers in the form of higher wages. If we take this argument to its logical limit, recommendation #4 is superfluous: once total payments are capped, hospitals could decide internally how to allocate their resources.

But we added recommendation #4, because we believe that in the past, wage settlements in health care have tended to become part of the total budget, in effect lifting the cap. In other sectors, higher wage settlements often translate into fewer jobs, but in health care this tough stance has turned out to be very difficult to maintain and recommendations #2 and 3 may not be sustainable without recommendation #4. Labour strategies are discussed in more detail in ***Labour Relations***.

Capital Expenditures

The successful restructuring of BC's hospital sector depends not only upon the expectations and cooperation of the people who work in it, but also and most importantly, on the way in which new capital - beds, diagnostic equipment, therapeutic facilities – is added to it. It will be difficult if not impossible to overcome a very great momentum for business as usual, if capital planning and projects result in ***capital expansion as usual***.

The Ministry of Health's plans for the construction and maintenance of hospital buildings and equipment are contained within the Five-Year Capital Plan. The current plan (1990/91 to 1994/95) calls for the expenditure of about $1.5 billion at current prices over the next five years to expand and renovate the existing hospital and *intermediate care system.

The plan projects a continuing slow decline in the province's average ratio of acute care beds for each thousand of the population, from 3.96 at the end of 1988/89 to 3.68 in 1994/95, with a target ratio of 3.50. But since the population of BC is projected to continue to increase, this slow reduction in per capita supply will actually involve substantial new construction. According to current population projections, 836 new acute care beds will have to be added to the 1989/90 inventory if we are to reach the 3.68 bed to population ratio by 1995. A further 440 beds will be needed by the year 2000, even if the ratio falls to 3.50.

The commission is concerned that this construction program will continue the current patterns of acute care hospital use

* GLOSSARY

and eliminate the possibilities for a major reallocation of resources for a decade or more. Although the funds necessary for capital construction are not large relative to the overall cost of providing health care services, ***if these projects are built, staffed, and used, few additional resources, if any, will be available for other projects well into the next century***.

This may seem too pessimistic a judgment. The ministry does, after all, project a continuing decline in acute care bed capacity, and quite explicitly identifies the need for a shift in priorities from the acute care sector to the community. Moreover, current plans are only the latest stage in a long, slow process of reduction and substitution in the acute care sector in BC. Our pessimism, however, is based on our analysis of hospital use in the metropolitan areas. This shows that the number of acute care beds actually available for the metropolitan population is already far below the five-year target of 3.68.

Bed to population ratios are based upon the reported number of beds available to a population. However, this must be adjusted for three factors:

- in and out referrals of patients
- bed or ward closures
- long-term patients in acute care beds.

There has to be the political will
to really close beds.
If you have shorter
lengths of hospital stay,
early discharge,
fewer problems,
you've actually got to have the will
to either close the bed
or defer building new hospital beds
and staffing them.
HCP-004

Since the Capital Regional District (CRD) and the GVRHD serve as referral centres for BC, a significant share of the beds in each region is, at any given moment, occupied by residents of other parts of the province. This means that the stock of beds located in these regions includes a proportion which are available to the provincial population and should not be counted as part of the local bed to population ratio. Metropolitan residents may use hospital facilities outside the CRD/GVRHD but, in fact, relatively little of this reverse flow occurs.

Furthermore, hospitals often respond to seasonal fluctuations or budgetary pressures by closing beds or wards, which also reduces the number of beds available for the use of local residents. There is also a substantial number of beds, at any given time, occupied by long-stay patients. Some of these patients may have been assessed as being eligible for continuing care in other institutions, but many are simply in an acute care bed for a long period of time, without any formal assessment.

In the course of this commission we received Ministry of Health data on patterns of bed closures in the CRD and GVRHD in 1988/89 and 1989/90, and carried out an analysis of patient discharges to find out what proportion of patient days were accounted for by people with residences outside these regions, or by people whose assessment status, diagnosis on *separation, or length of stay indicated that they were not acute care patients.

This analysis showed that in 1989/90 there were 6,676 approved acute and short-term rehabilitation beds located within the metropolitan regions, a ratio of 3.82 for each one thousand people. However, the number of beds actually open fluctuated over the year, and the average level was only 3.51 per thousand. Moreover, nearly 15 percent of the inpatient days in these regions were accounted for by patients referred in from elsewhere in the province. Therefore, the beds open and available to metropolitan residents were only about three per thousand.

The proportion of these beds taken up by long-stay patients was then estimated by identifying all those who:

- had been assessed as eligible for continuing care while remaining in an acute care bed
- had a separation diagnosis of "awaiting placement"
- had a length of stay of 30 days or more.

The long-stay days were estimated as: all of the days of those patients assessed for continuing care or diagnosed as awaiting placement, *plus* the 30th and subsequent days of those with long stays who were in neither of these categories. These estimates indicated that between a fifth and a quarter of the acute care beds available to local residents in the metropolitan regions were being used by long-stay patients.

While many of these patients were identified as awaiting placement, or as assessed for long term care, the majority simply stayed a very long time in hospital. Therefore, the numbers of acute care beds actually available for metropolitan residents in 1989/90 were between 2.25 and 2.40 per thousand population. ***Approximately half the population of British Columbia is already being served by an acute care bed capacity which is more than a third less than the 3.5 beds per thousand population target that the government hopes to achieve in the next ten years.***

But even these figures, by assuming that all hospital use by patients staying less than 30 days is appropriate, may overestimate the level of acute care bed capacity which is necessary to provide high quality health care. The commission has been told that hospital use by patients who are not long-stay can be reduced in a number of ways, including the increased use of day care surgery, outpatient and early discharge programs, and by more careful monitoring of lengths of stay.

To gain an idea of the number of beds necessary to provide British Columbians with good health care, the commission contracted with a firm of consultants in managed care who studied the discharge records of patients in acute care during fiscal year 1989/90.

This study, described in more detail in ***Hospitals***, showed that, relative to accepted norms, British Columbians could have saved approximately 680,000 acute and rehabilitation days of care by shortening average lengths of stay, and could have eliminated about 30,000 inpatient stays entirely. This is a potential reduction in inpatient days of over 25 percent on a base of about 3.2 million days. Moreover, the study did not include occupants of acute care beds who had been assessed as eligible for long term care. These patients currently account for another 250,000 days annually.

The commission believes that while the Ministry of Health is well aware of the need for a shift in emphasis from the acute to the long term care sector, its current plans do not go far enough in this direction. Its construction proposals actually represent a minimal adjustment from established patterns. They will therefore have the effect, despite their good intentions, of entrenching current inappropriate patterns of care for another decade or more.

... our hospital has been occupied between 25-30% by long term care patients. The net effect to us is that we have 1.7 acute beds per 1,000 population. We've coped with it in a number of ways, one of them is by reducing length of stay by 3 days. We've increased our outpatient systems enormously - surgical daycare, and ambulatory daycare. We've created an emergency response system, a lifeline, in order to try and keep people at home. We've evolved a quick response system in the emerg. so we can triage people who ought not to be there, so they don't enter the hospital and occupy an acute care bed. We've started a health promotion centre in the centre of town. We have instituted a seniors' study, involving the seniors...

HOS-110

Therefore, the commission recommends that:

5. **the Five Year Capital Plan of the Ministry of Health be revised to**
    a. **establish a provincial average of 2.75 acute care beds per thousand population to be reached by 1995;**
    b. **include a major expansion in the capacity of long term care facilities to support the transfer of the long term caseload out of acute care beds;**
    c. **expand ambulatory and day care facilities, either hospital-based or free-standing institutions, to substitute for *inpatient care; and**
    d. **plan for the needs implied by population trends over the next 20 years, paying particular attention to the projected growth of the very elderly population, i.e., those over 80.**

The commission recognizes that the special circumstances of people in rural and remote regions of the province may necessitate greater availability of beds. Hospital stays may be longer for people who are far from home and cannot easily be readmitted if discharged too soon. And the only hospital in a large rural or remote area must keep more beds empty, on average, in case of unexpected needs.

It is difficult, however, to distinguish between genuine need and inefficient *utilization management or economic development objectives. Moreover, most of the people in the interior of BC actually live in small cities or towns, where their access to local hospitals may be as good as, or better than, that of a metropolitan resident. In any case, 2.75 acute beds for every one thousand people is well above our estimate of actual use in the CRD and GVRHD, and leaves a good deal of room for rural and remote differentials.

Changes in the regional distribution of populations will complicate the process of downsizing. The very rapid increases in the Fraser Valley's population are being accommodated, in part, by referrals into the GVRHD. If the intense pressure for expansion of acute care facilities south of the Fraser River is met by new construction, there will have to be further reductions in acute care bed capacity in the GVRHD in order to stay within the overall targets.

The current Capital Plan also provides for the expansion of *intermediate and *extended care facilities by 10.95 percent over five years. But, because of the aging of BC's population, this actually represents a decline of nearly 5 percent in the ratio of long term care beds to the 65 and over population. It is argued, though, that since *personal care (Level 1) beds are being phased out and replaced by Levels 2 and 3 beds and expanded home care, the plan actually provides for increased capacity.

Again, however, we think that the plan does not go far enough. To begin with, it is important to understand that seniors are not a uniform group. It is the frail elderly – mostly people over 80 – rather than people over 65, who are heavy users of long term care. As described in the introduction to this report, this group is projected to grow much more rapidly than seniors as a whole. Relative to the over 80 population, the plan's projection of long term care capacity implies a decline of beds per capita of 15 percent over five years.

The shift in focus to the very elderly rather than all seniors has large implications for health care in BC. Maintenance of the 1989/90 ratio of long term bed capacity to the 80-plus population would require nearly 5,000 more beds by 1994/95, in addition to those already planned. Even assuming, as the plan does, that there can be a shift of 1500 beds from Level 1 care to Levels 2 and 3, the ministry would still have to double its projected construction of new long term care beds to maintain the current levels.

In addition, the transfer of long term care patients from the acute care sector, which this commission recommends, will require at least 1,000 – perhaps closer to 2,000 – more intermediate and extended care beds, depending upon the scope of expanded home care programs. This implies a tripling of the beds now projected to be added to long term capacity.

The phrase, *depending upon the scope of expanded home care programs,* is critical to this projection. We know that there will be many more very elderly people in BC in the near future: the over-80 population is expected to rise by more than 30 percent in the next five years, and by 65 percent in this decade. The key questions are, how many of these people will need long term care, and for how long?

The ministry's limited capital expansion plans rest on the assumption that a significantly higher proportion of elderly people can be maintained at home than is currently the case. This will require major expansion in home support programs, which the commission strongly endorses.

There is also a view among some analysts that an increasingly healthy senior population may not need the same level of institutional care as in the past, although this is a speculative and contentious idea. It would be unfortunate, though, if, having seriously overextended the acute care system in the last generation, we were now to entrench patterns of institutional care for the elderly which are equally inappropriate.

We believe, on the basis of current population projections and patterns of use of long term care, that a major expansion in long term institutional capacity will be necessary. We believe also, that there will be a particular need for more extended care beds to accommodate both the long-stay patients currently in acute care and the increasing numbers of very dependent seniors who cannot be maintained at home. But if it should be shown, over the next five to ten years, that expanded home support programs and more flexible, *multi-level residential facilities can dramatically reduce the need for more beds, we would be very pleased to be wrong.

New facilities cannot be created overnight, however, and the very elderly population is projected to increase very rapidly. The effectiveness of home support programs, and the speed of conversion of lower level intermediate care beds, will thus have to be monitored very closely to ensure that their capacity is keeping up with this growth.

Our recommended target of 2.75 acute care beds means that there will be a fall in the absolute numbers of acute care beds from about 11,500 to about 9,500 by 1995. These beds could, if converted, go a considerable distance towards satisfying the need for additional long term care beds. Indeed, this is in effect what is happening: many acute care beds are now permanently occupied by long term care patients.

However, we do not think that this is a satisfactory solution. These people remain patients in hospitals, rather than residents in homes which happen to be institutions. Quite apart from the additional cost, both capital and operating, an acute care hospital is not a home. It is not an appropriate substitute for properly designed institutional homes.

* GLOSSARY

While the ministry's current policy of shifting long term care beds from Level 1 to Levels 2 and 3 may be appropriate, the commission believes that it may also be possible to delay institutional care by developing types of housing which support independence and self care. Since large increases in BC's elderly population are projected far into the future, it seems prudent, as well as humane, for the Ministry of Health to assist in developing and evaluating these alternative models of residential care. While no single model of this sort appears to have emerged, we have been told of a number of promising examples in this province and elsewhere.

We must emphasize, though, that moving long-stay patients from acute care beds to more appropriate institutions or programs is only part, though a large part, of the process of reducing the acute care sector. There are still other opportunities for the substitution for, or better management of, inpatient beds which do not need to wait for the construction of alternative facilities. Moreover, there is a long history in health care of adopting alternatives which turn out to be add-ons, and of confidently promised savings that somehow never appear. Therefore, it is essential that there be substantial and enforced cuts in acute care bed capacity along with the expansion of other types of facilities. The inpatient bed to population ratio must decrease.

The Management of Health Care

Capping budgets and limiting the supply of facilities and personnel represent the extension of traditional ways of controlling costs in the health care system. They are applied in the belief that better management of the existing resources, and a redeployment of resources from one sector to another, can improve the health and happiness of British Columbians without continually increasing the share of provincial resources absorbed by the system. But these mechanisms improve management indirectly. They squeeze the existing system to make business as usual uncomfortable or impossible. They do not, in themselves, provide either tools or direct incentives for better management.

Although the commission has received a number of submissions pointing to inefficiency and waste, we do not believe that they reflect incompetence or a lack of dedication by those working in the health care system. Rather, they are the consequence of a pervasive lack of management and accountability. Better management at all levels is the single most important idea in cost control. This not only includes *doing things right*, but even more importantly *doing the right things*. In a number of situations, this may imply not doing what is presently done.

• *Doing the Right Things*

The present problems cannot be corrected overnight, nor can any single body produce a blueprint for change. However, we do have certain recommendations which we believe may lead in the direction of more appropriate and less costly care. These are derived from a five-part strategy for improved management, based on:

- the cooperative development and dissemination of new practices
- providing alternative programs and facilities
- generating and disseminating comparative information
- financial incentives
- overall funding limits.

Applying these components to the acute care hospital sector begins with the observation that, for a variety of reasons, there is significant over-use of acute care beds. As noted above, a study for the commission reached a conservative estimate that 680,000 acute care days in BC hospitals resulted from unnecessarily prolonged stays, and 30,000 inpatient stays could have been eliminated completely.

A number of considerations, including these data, have led the commission to recommend a reduction in the number of acute care beds per capita.

This will require a corresponding reduction in per capita rates of use of acute care beds by about 25 percent over the next five years. Since the population is projected to increase over this period, the net decrease in the total numbers of bed-days used would be between 10 and 15 percent.

In making this recommendation, we recognize that conditions and needs vary across the province, and that in regions experiencing rapid population growth, bed availability and use may be low. However, the target of a 25 percent reduction is based on what is possible, on average, for the province as a whole.

Problems with access to hospital care for certain procedures, excessive waiting times, and rescheduling – which causes patients serious inconvenience, suffering and extra cost – were all brought to the attention of the commission. But we believe that these very real problems often result from inadequacies in the availability, scheduling, or use of diagnostic or therapeutic services in hospitals, and do not reflect a general shortage of inpatient beds.

In particular, we were told of excessive waiting times for cardiac or orthopaedic surgery, merely because a hospital had exhausted its budget for pacemakers or hip prostheses. This form of cost control seems penny-wise and pound-foolish, and it reinforces the erroneous public perceptions of bed shortages.

We believe that reducing per capita, age-adjusted acute care bed use by 25 percent is consistent with maintaining access to hospital care, and improving it. This will, however, require more effective management of the available beds, as well as the province's providing alternatives to hospital care. It would be unacceptable to the commission, and to the people of BC, if a 25 percent reduction in inpatient days was achieved by closing wards and allowing waiting times to increase, while the present inappropriate patterns of hospital use continued.

The acute care days which we believe can be eliminated fall into several categories:

- very long lengths of stay for patients who need some form of care, in an institution or at home, but who should not stay in acute care
- inpatient stays for patients undergoing procedures which could be performed on a same-day basis in hospital, or as an outpatient procedure, or at home
- appropriate hospitalizations with unnecessarily prolonged stays.

A fourth possible source of unnecessary days may be added to the above list: diagnostic or therapeutic procedures which should not be done at all, in hospital or anywhere else. The extent of such use is unknown, but it may be significant.

To lower the overall rate of inpatient use, the ministry should establish standard patterns of appropriate care for common diagnoses and procedures. These standards can be based initially on the average pattern for the province as a whole, but should then be refined further by examining experiences elsewhere and exploring the medical literature for "best practice" possibilities. Special circumstances which justify exceptional patterns of care should also be identified and documented.

Similar efforts have begun in other jurisdictions, and standards have been developed in some areas, such as in the frequency of caesarean sections, the length of stay for acute myocardial infarction and the proportion of hernia repairs performed as same-day surgery. But hospitals and physicians have never been asked to account for deviations from these standards or to bring their patterns of practice into line.

Therefore, the commission recommends that:

6. **the Ministry of Health, in cooperation with hospitals and their medical staffs, develop provincial standards for patterns of care for common hospital procedures. These standards shall be public, and shall be used to identify regions and hospitals where acute care hospital utilization is excessive. Hospitals exceeding the standard shall be expected to modify or justify their practices.**

Although the standards for care for a particular procedure or diagnosis should initially be based on a provincial average, they should not remain that way. A hospital which is successfully caring for patients in a less intensive manner than the average should become the basis for the standard, and not be encouraged to increase to the mean. In particular, hospitals which have introduced utilization management programs, discussed more fully in ***The Best Care***, could serve as sources of information as to what can be achieved, and their successes can be made widely known and used as a basis for evaluating other hospitals.

The primary emphasis in the process of reducing acute care use must be on the cooperative development and dissemination of new practices and procedures, and of comparative information. There must be simultaneous development of alternative facilities or programs where necessary. And the ministry should work with the hospitals and their medical staffs, and with Continuing Care, to manage the shift of patients and resources. But it may be necessary to provide some financial incentives, or at least remove financial disincentives, for hospitals to make these adjustments.

Under the system of health care described in ***The Management of Health Care Services*** and ***Hospitals,*** funds are allocated to each region of the province on the basis of its population and other characteristics. These funds are then distributed to the institutions and programs providing services to patient populations, which, in the case of hospitals in particular, may be outside the region. This allocation must take into account the share of the non-regional workload borne by each institution. But any unnecessary services should not count in a hospital's workload, so that there is a financial incentive to improve management.

Therefore, the commission recommends that:

7. **Hospital Care provided beyond the standards developed for particular procedures not be included in a hospital's *weighted patient day, or workload base, for the purpose of allocating regional funds among hospitals.**

Of course, departures from the provincial standards which have a perfectly good explanation in the special situation of a hospital or its patients would not result in any reduction in payment. In general, the commission thinks that financial penalties should apply only at the end of a cooperative process of attempting to modify or justify deviations.

• *Long-Stay Patients*

The largest single source of unnecessary acute care days is long-stay patients in acute care beds who do not belong there. The commission has already recommended a substantial reduction in acute care bed capacity and a corresponding increase in the availability of alternative facilities and programs to delay or prevent institutionalization. But patients must also be moved out of acute care beds, or the new capacity will simply lead to an increase in overall use.

At present, bed days assigned to patients occupying acute care beds but assessed for continuing care account for a minority of the total days provided to long-stay patients. Increasing the proportion of long-stay patients in acute care beds who have been assessed for continuing care, in combination with increasing the province's continuing care capacity, would encourage the transfer of patients.

Therefore, the commission recommends that:

8. any patient who has been in acute care for more than 30 days shall be deemed to be discharged from acute care to continuing care, unless specifically assessed every 30 days as requiring continued acute care.

9. the patient days of patients transferred to continuing care while in an acute care bed shall no longer be included in the hospital's weighted patient-day count.

Patients who have been assessed as eligible for continuing care but who occupy acute care beds, do not now pay the per diem charge which is required of those people in intermediate or extended care. The justification for this charge is that when people enter long term care, they no longer maintain a separate household. Therefore the charge is in lieu of food and lodging costs which people in the community pay out of pocket.

We think that patients in acute care beds who have been assessed for long term care should pay this charge. However, those deemed to be discharged after 30 days' stay in acute care may not have had time to consider alternative arrangements. Therefore, it seems fairer to postpone the per diem charge for 15 days after they are deemed discharged. Of course, the charge should be waived in cases of severe hardship.

Therefore, the commission recommends that:

10. patients discharged to, or assessed as eligible for, continuing care who remain in acute care beds, shall begin to pay the per diem charge for continuing care starting 15 days after the date of assessment or deemed discharge.

Providing public information on patterns of use and lengths of stay is also an important part of management strategy. The regionalization of planning responsibility, and funding envelopes, both discussed in ***The Management of Health Care Services***, imply that decision makers, and their advisors at the regional level, need to know more about what is going on in the hospitals serving their regions.

At present, a hospital with long lengths of stay may argue for a larger budget from the provincial government on the basis of its workload. This argument is usually supported locally, whether or not it is valid, since hospitals are an important source of local income. However, when the total health resources for the regional population are capped, there will not be any gain from inappropriate use, and the community's energies can then be redirected toward more effective hospital use, and support for other programs.

Therefore, the commission recommends that:

11. the Ministry of Health make public information on the number of patients staying in acute care beds for longer than 30 days, the number of patient-days provided to them by each hospital and by each region, the number of long-stay patients and the number of days of care assessed as appropriate for acute care.

• *Home Care*

These measures are all meant to encourage the transfer of patients from acute care to long term care and home care. And since workload is being transferred from one setting to another, jobs will have to be transferred as well.

Large numbers of health care workers, particularly nursing personnel, will have to be transferred from hospitals to home care programs. And this transfer must not be hampered by inappropriate requirements for educational or other qualifications. ***Nursing personnel qualified to provide care on a general hospital ward must be accepted as equally qualified to provide the same care, to the same patients, in their homes.*** Otherwise, the principle of shifting the site of care closer to home, which was widely supported in submissions to the commission, will be subverted.

Therefore, the commission recommends that:

12. the home care programs, which are to be expanded to care for patients moved from acute care settings, make explicit efforts to recruit staff from hospitals so as to ease the transition process.

It must be underlined, however, that the thrust of the commission's recommendations is to move patients from one care setting to another, not to encourage an expansion in care. We are well aware of the strong tendency for new or expanded health care programs to be advocated and introduced as alternatives to some existing activity, only to become an addition to the existing programs. That must not happen if British Columbians are to be successful in restructuring their health care system.

Moreover, while we have focused on inappropriate care in hospitals, we do recognize that there is at least as much scope for inappropriate care in the home. Yet, when both patients and providers have come to expect, over many years, that certain patterns of care are necessary for safety and health, a margin of extra home care may be needed to support both the caregiver and the care-receiver through the transition to a system of early discharge and outpatient care.

For example, successful day care surgical programs have found that an initial, relatively generous schedule of *home nursing visits helps physicians and other hospital staff, and patients, to gain confidence in the process. Once a routine is established, regular home visits are not necessary as long as patients have access to advice and help as needed. By *needed*, we mean advice and help *effective in preventing or remedying specific adverse outcomes associated with early discharge*, and not merely a source of client or caregiver satisfaction.

Therefore, the commission recommends that:

13. **the increases in home care budgets to provide for patients transferred from acute care be no greater than those services would have cost in acute care.**
14. **specific and well-defined programs to reduce inpatient utilization, e.g., early maternal discharge, be well supported with home nursing care in order to establish confidence among, and ensure acceptance by, providers and patients.**
15. **any home nursing adjuncts to, or substitutes for, inpatient care must be subject to careful evaluation of outcomes, using measurable criteria.**
16. **once the new program is established, services provided to help this transition should be discontinued unless justified by measurable criteria.**

The commission has been warned of the danger of *outcome drift*. This is the tendency of home care programs to emphasize and evaluate themselves on psycho-social or other measures of effect, different from, and additional to, those applied to hospital care. This selection of additional objectives can very easily become a justification for a program which is simply an add-on to existing programs. ***A primary rule for evaluating any home care alternative to hospitalization must be that it can be shown to reduce hospital use***.

Home care cannot lower the total system costs unless it's growth is accompanied by actual reductions in the supply of institutional services. We cannot continue to add on and add on.
HUT-006

Therefore, the commission recommends that:

17. **the criteria for evaluating any home care alternatives to hospitalization be that the program's goals are to achieve results equal to, or better than, those achieved in hospital, and thus substitute for hospital care.**

* GLOSSARY

Because the per diem cost in hospitals includes all the costs of diagnostic and therapeutic interventions for short stay patients, it overstates the savings possible through shortening stays and transferring very long stay patients. Therefore, the extent of the increase in continuing care spending must be determined on the basis of the more limited savings in acute care. This limitation is not to be applied to individual patients, since the acute care costs of an individual patient are only an estimate. Rather it should apply to the overall increase in the budget for continuing care.

As substitute programs for inpatient care are phased in, the unit costs of the alternative programs should decline. There will be gains from economies of scale and increases in experience, and components found to be unnecessary or ineffective can be discarded. Savings in the hospital sector should also increase as the effect of substitute programs on hospital workloads becomes large enough to permit wards to close, and staff to be released.

However, if the least acutely ill patients are transferred first, then, as the programs expand, their patient population will become, on average, sicker. And so will the patient population in the acute care system. There will still be savings as the programs expand, but they will become smaller.

> *I've seen a number of experts who estimate that 1 out of 4 that we put in institutions might be treated some other way or treated in a lower cost institution than the one they're in.*
>
> SOC-047

• *Contracting for Services*

Each episode of care, in or outside of a hospital, is made up of a package of services, and each item of service within each package should be both appropriate and efficiently produced. Any analysis of costs in the health care sector tends to focus on hospitals, because hospitals account for so large a proportion of the budget, and on patient days, because they are easy to count. The commission has been told of the advantages of free-standing (non-hospital) facilities – day surgery units, birthing centres, abortion clinics – which seem to be able to provide services more efficiently and with more flexibility than the equivalent hospital based programs. The roles and activities appropriate for such facilities depend upon the level of development of health care in their area. For example, in a metropolitan area, with extensive back-up to help deal with unexpected complications, a free-standing facility may take over a number of quite technical activities usually carried out in hospitals. In a more remote region, a free-standing facility might provide services presently fragmented by budgetary or *scope of practice distinctions, such as those that separate home, hospital and *public health nurses, or nurses and diagnostic technicians.

For some of these free-standing facilities, birthing centres and abortion clinics for example, the overall workload is well defined and payment by volume is appropriate. For others, such as day surgery or diagnostic facilities, experience indicates that payment by volume can lead to excessive use. A contract for a specific number of procedures might be more appropriate, with the decision as to who shall be served by the facility made by people who are strictly separate from it.

The general principle we are stating here is that the concept of contracting for services can be extended beyond such traditional areas as laundry or food services, to include professional services wherever these are carried out in large numbers and on a relatively standardized basis. There is, of course, nothing to prevent a hospital bidding on these services, just as a hospital may choose to do its own laundry or cooperate with other hospitals to establish a regional laundry. However, if a free-standing facility can carry out day surgery *more efficiently* than the hospital, then the hospital's budget can be reduced by more than the payments to the facility. These freed-up funds will then be available for other programs within the hospital or elsewhere in the community.

Therefore, the commission recommends that:

18. the Ministry of Health

- **a. encourage the development of free-standing health facilities to provide some of the services now carried out within hospitals; and**
- **b. reimburse such facilities on contractual terms based upon some combination of volume and population served.**

Other forms of contracting-for-service can be applied to expensive, high-tech facilities. For example, magnetic resonance imaging (MRI) equipment is very expensive to purchase and house, and the cost of each procedure is significantly reduced if the facility is run for two shifts a day. Obviously, a hospital having such valuable equipment should operate it for more hours and contract out extra hours for the use of physicians from other hospitals, but this does not happen. While MRI equipment is being used only one shift each day at Vancouver General Hospital, at least two other hospitals in the GVRHD are trying to get their own MRIs. This seems to be a case where convenience and prestige are an objective of the hospitals and staff while the costs are borne by the taxpayer.

Nor is this problem restricted to the high-tech, high-profile facilities in *tertiary care hospitals. We heard of opportunities in the Interior for sharing underused diagnostic facilities. But it is easier and more convenient for a hospital or community to lobby for its own facility than to work out a time-sharing contract. Hospital fundraising efforts to purchase imaging equipment further complicate the problem. As pointed out in ***Diagnostic Imaging Services***, such efforts actually increase health care spending, because new equipment means new operating costs.

Therefore, the commission recommends that:

19. the Ministry of Health, in cooperation with hospitals and medical staffs, develop contractual arrangements such that facilities located at one site are made available on equivalent terms to practitioners from other hospitals, on a shared-time basis.

In this arrangement, the time contracted for belongs to the *guest* facility. Any requirements for admitting a patient to the *host* hospital, or for the use of the host hospital's medical staff, or that the host hospital be unilaterally able to put one of its own patients into a block of time contracted for by the guest hospital, are incompatible with this policy. We understand that the failure, or unwillingness, to recognize this transfer of rights has already led to the breakdown of one such attempt to share high-cost diagnostic facilities in the GVRHD, to the taxpayer's loss.

The panel was initially asked to prepare indications for coronary artery bypass grafting, which we submitted - it's about a 40 page document. We then went on and delivered to the provincial government indications for percutaneous coronary angioplasty, pacemaker insertion, exercise testing, echo-cardiography, delivery of pediatric services...
SOC-034

There are also a number of possibilities for contracting for service which are not frequent and standardized, such as the service offered to the province by the Provincial Organ Retrieval for Transplantation Service. Cardiac surgeons in the province are already working together to develop uniform data gathering systems and treatment protocols. The ministry might contract with such a group to develop protocols and data systems, or for assistance in developing ways to monitor practice, ensure compliance with protocols, or actually deliver services in a particular area.

Ophthalmologists in Vancouver are also working to set guidelines for who should have surgery, how it should be carried out and what results should be expected. Although it would be impossible for a single group of ophthalmologists to contract for services for the whole province, they might be able to assist in setting up other similar groups elsewhere. They might also be able to contract, as a group, to provide services in the Vancouver area.

These contracts would have to include explicit provisions for evaluating the effectiveness of these arrangements. They would have to be flexible enough to evolve over time, and to enable other practitioners to submit alternative bids for consideration. This should help to determine the best patterns of practice and to promote them across the province.

These contracts must not permit a select group of practitioners or service providers to become the owners of any field, or to freeze in place a particular treatment pattern. New people and new techniques must always have the opportunity to prove themselves.

Therefore, the commission recommends that:

20. where appropriate, the Ministry of Health develop contractual arrangements with one or more groups of physicians to define protocols for, or manage, the provision of certain highly specialized services, on a regional or province-wide basis.

Non-Hospital-Based Care

Procedural protocols, comparative performance data, contracting for services, financial incentives – all of these apply to institutions or to medical procedures carried on within institutions. Yet a significant proportion of health care activity, and its associated costs, takes place in physicians' offices or outpatient clinics. Such services are identified only by a visit code in the *fee-for-service schedule, although we understand that efforts are being made to have diagnostic information attached to each billing. But Manitoba has already demonstrated that diagnostic data on office visit records make it possible to assess patterns of office-based care more effectively, and to analyze the nature of the care. If physicians are expected to provide this information, it must be valuable to them.

Therefore, the commission recommends that:

21. a. physicians be encouraged to provide diagnostic information for each patient contact; and

b. the ministry and the BC Medical Association jointly develop a form of reporting back to individual physicians, through the computerized billing system, which will provide them with relevant information on the patterns of illness of their patient populations.

The collection of diagnostic data in a consistent format, through a computerized link, would give physicians access to up-to-date information about the frequency and trends of illnesses and problems in their patient populations. It could also be used to alert physicians to unusual patterns among their patients or among the patients in their regions, thereby providing a form of sentinel service that watches for changes in amounts and types of illness.

The cooperative development of such a system is important if it is going to generate information useful to practitioners, rather than acting as merely another way to monitor information for the ministry's purposes. Properly organized, it could provide a rich new source of information on *health status, as reflected in the use of *ambulatory care.

The commission has also been told of abuse of the health care system by patients, of the frequent and unnecessary use of physicians for trivial complaints and social reasons. We understand that there is a program already in place whereby doctor-shoppers (patients who visit a number of different practitioners without referral) can be identified, and asked to select a single practitioner as their point of entry for care. This program appears to indicate that the problem of patient abuse is smaller than is often believed. But we are uncertain that this is a complete picture of inappropriate use of ambulatory care. Moreover, the present system places some burden on the practitioner to establish if the patient is assigned to another physician at the beginning of a visit.

Therefore, the commission recommends that:

22. the Ministry of Health and the BC Medical Association

a. work together to determine if "doctor-shopping" and overly frequent and unnecessary visits to physicians are a significant problem by analyzing patients' patterns of office visits to general practitioners; and

b. make public their findings on the effect of such inappropriate use on costs, personnel time and quality of care.

23. patients who are found to be making inappropriate use of physicians' services be assigned to the general practitioner of their choice, and their use patterns be monitored. The computerized billing system should be used to label the numbers of patients assigned in this way, so that other physicians contacted by such patients are aware of this pattern of behaviour.

If persons are identified as making persistent, inappropriate use of ambulatory care, and the problem cannot be resolved by professional advice, such care-seeking might be interpreted as not medically necessary, and would thus become the financial responsibility of the patient.

Educating the Public

A lot of people go to a doctor, say to the doctor, here is my body, fix it. But we are responsible for our health all the time. We are the healers, not the doctors.
SOC-126

One of the five principles of Canadian health care is that all medically necessary care will be provided without financial barriers. But, as the commission has been told on a number of occasions, for this principle to be upheld, the public must use the health care system responsibly. We agree, and we also believe that the vast majority of people do try to use the system responsibly, and that it is a small group of exceptions who are noticed by practitioners because they are unusual. However, to use the system responsibly and appropriately, the general public must have enough information on which to base their decisions to seek care.

At present, most, if not all, of the information received by the public from the media and from professional groups concerns "When to see your doctor." This situation has recently been made worse by advertising campaigns which recommend, for example, seeing a physician to get a prescription for a rather doubtful hair restorative. Another problem is the development of private companies running house-call services which specifically recommend that the persons using these services also see their own doctors. Walk-in clinics are also a possible source of double servicing. Although studies in other provinces have not supported this concern, the growth of such trends should be watched.

Obsolete or otherwise totally inappropriate administrative requirements for diagnostic procedures or health evaluations also add pressure to the health care system, and, in the process, often stretch the definition of "medically necessary". For example, we have been told that many intermediate and long term care institutions require their residents to have a chest x-ray on admission. This is a complete waste of time and money, quite apart from a gratuitous exposure to ionizing radiation. Other procedures – health examinations, diagnostic procedures and documentation requested by potential insurers or employers, or by employers to confirm sick leave – may be administratively appropriate but are clearly not medically necessary. *MSP should not pay for services which are not medically necessary.* This would include the vast majority of such things as cholesterol testing and pregnancy ultra-sound. These services can be provided at the patient's expense, if, and only if, they do not prohibit the services being provided to those people who medically need them.

Therefore, the commission recommends that:

24. the Ministry of Health and the BC Medical Association work jointly to
   a. develop public information materials on when *not* to see your doctor, and on basic home diagnostic procedures to assist in deciding whether or not to seek care; and
   b. investigate the effect of commercial advertising campaigns and alternative forms of medical organization on rates of visits to general practitioners and consider restrictions or compensatory taxes on activities which can be shown to stimulate unnecessary utilization.

25. the Medical Services Commission establish as a principle, and make clear to practitioners and to the public, that any visit to a practitioner and any associated procedures required for reasons other than medical necessity, are not reimbursable by the Medical Services Plan.

An advertising campaign, sponsored by the Ministry of Health and the BCMA, to inform patients of specific ways to use the system more responsibly is a public education initiative which could be considered. A telephone hotline, staffed by nurses, to provide basic medical advice or simple reassurance is another. Some capitated plans in the United States already use this type of system successfully, not to give general health information or advice, but to respond specifically to a patient's illness or injury, thus reducing the rate of office visits. A province-wide service (1-800-REA SURE) could perform the same function.

These recommendations rely for their effectiveness on the hard cap on total annual billings as described in recommendation #1. In an open-ended, fee-for-service environment, with an ever-increasing supply of physicians, it would be difficult or impossible for the BCMA to cooperate in efforts to limit the growth in use of physicians' services, inappropriate or otherwise. The BCMA represents the economic interests of physicians and it can hardly be expected to help develop ways of lowering their incomes. Yet its cooperation is essential, both for its capability and for its credibility. And in a globally capped environment, the BCMA can participate in serious efforts to promote more appropriate use of physicians' services without threatening its members' economic interests.

The Market Place

The principal focus of the recommendations in this chapter has been on those services, medical and hospital, which are the financial responsibility of the provincial government. However, health care costs, and our mandate, are not restricted to those services paid for or provided by the provincial government. In particular, a significant share of health care spending in BC is for prescription and non-prescription drugs, and for dental care. These payments are usually made by individuals out of their own pockets, although, as discussed in ***Prescription Drugs***, Pharmacare does reimburse people for a large portion of the cost of prescription drugs. As well, there is quite extensive private dental insurance for large groups of employees.

The provincial government does not negotiate or regulate the costs or prices of the components of health care for which it does not pay. Instead, normal market-place pressures are supposed to result in an appropriate level and pattern of prices and costs. In fact, the provincial government itself relies to some extent on market forces to limit its own costs.

But the market for health care is rarely like a normal market. For patients to behave as prudent shoppers they must have information on the prices charged by different providers, and providers must genuinely be in competition with each other. This is not always the case.

For example, pharmacists in BC are forbidden by their professional body from advertising their dispensing fees. This denies buyers access to critical information and at the same time relieves pharmacists of a degree of competitive pressure on their fees and incomes. Prices are likely to be higher as a result of this lack of competition.

A similar lack of competition exists in the sale of certain types of non-prescription drugs which can be sold only subject to the oversight of a pharmacist. Quite apart from the question of whether oversight actually occurs, this restriction prevents other retailers from selling these non-prescription drugs in competition with pharmacists. Again, the effect is to relieve pharmacists of a source of competitive pressure which would tend to hold down prices as well as their costs for providing these goods and services. This is also discussed more fully in ***Prescription Drugs.***

For dentistry, the BC College of Dental Surgeons sets a fee schedule, which it estimates is followed by approximately 95 percent of all dentists in the province. There is no separate dental association, such as exists for physicians and other professions, and the college functions both as a body responsible for protecting the public interest and as a trade association representing its members' economic interests. Dental fees are therefore fixed without any negotiation or public oversight by a body whose accountability is profoundly ambiguous. This type of behaviour is fundamentally inconsistent with reliance on market forces to control prices and costs.

Therefore, the commission recommends that:

26. **the government of BC take steps to remove professionally-imposed limitations on the pricing and advertising behaviour of individual providers, for those health care services or products which patients must purchase at their own expense from providers whose prices are not regulated by an independent body.**
27. **the government remove from legislation or regulations any provisions which might place otherwise anti-competitive activities beyond the reach of the federal Competition Act.**

PART C: PEOPLE AND SERVICES

In the future, even more than in the past, the structure of the health care system must be defined by the needs and values of the people the system serves.

> *...there is an awakened conscience*
> *and a growing consciousness of the need*
> *for more organized assistance for the families*
> *carrying the unpredictable burdens*
> *of children with severe mental deficiency,*
> *children deformed or injured at birth or maimed*
> *in infancy, of members who are mentally ill,*
> *of members injured in accidents,*
> *of members who are aged and infirm...*
> *There is yet another major reason*
> *for an expanding public interest in health.*
> *It is the growing awareness of the cost to society*
> *as a whole of failure to be concerned*
> *and to act on behalf of its members.*

Royal Commission on Health Services, 1964. Vol.1.

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CHILDREN AND YOUTH

A society which does not value its children is ultimately unable to compete. Yet current health care spending frustrates our ability to invest in the future. To improve the health of children it will be necessary to change our priorities. Programs that reduce the rates of death, injury and illness among our children, that let them grow up without pain, fear or deprivation, will offer them fuller, more meaningful lives. The result will be to reduce the need for health care.

I
ask you
to take a moment
from listening
to all of the specialists
on acute care,
and think broadly about BC,
50 or 100
years from now,
because
the health care system
that we build today
will serve our children's children
tomorrow.
IND-331

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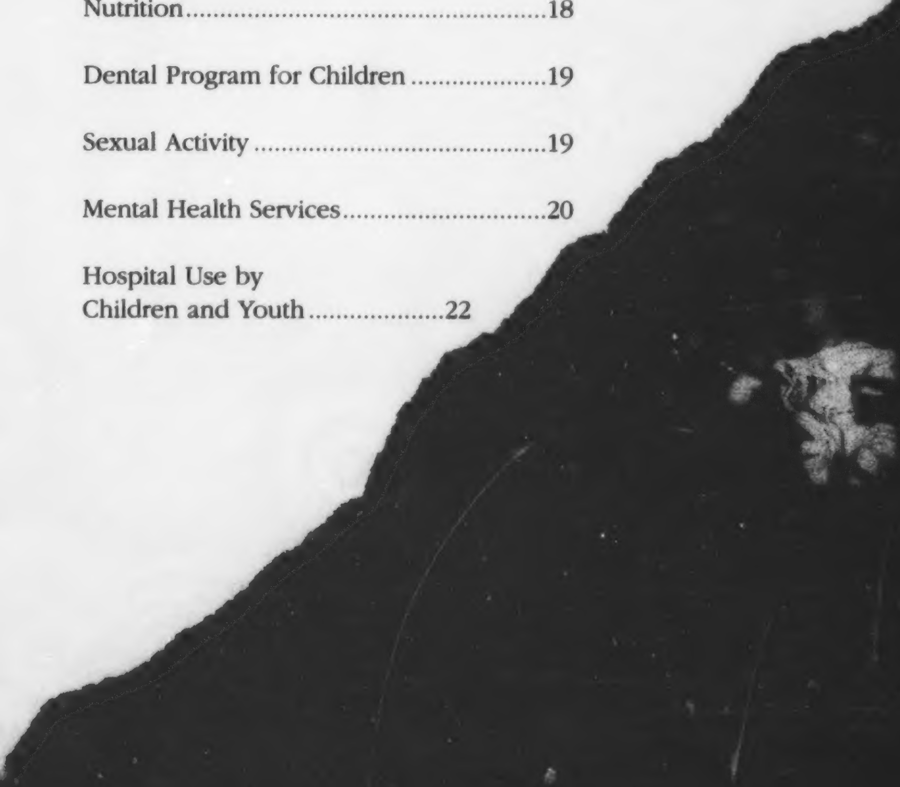


Families and Children

While there is a lot of talk about the growing number of elderly in the western world, there is very little said about the decreasing proportion of children or its effect on society. By the end of the century, the total number of children in BC will increase by 11 percent. But while children now account for 27 percent of the population, they will account for 25 percent by the year 2000 and only 23 percent by 2016.

What is often thought of as the *traditional* family does not represent reality in Canada. The image of mothers chatting across the fence while fathers go to work and children go to school with their siblings and neighbourhood peers is a product of the postwar years. Times have changed. Today, children are often alone in their neighbourhoods with few peers and with parents who both work outside the home. Nevertheless, public policy and attitudes remain lodged in the past.

Mothers, if they choose to stay home – and many do not have that choice – find information on raising children more difficult to get from friends and older family members. Formalized support services have now replaced many of the functions of the older, informal networks. Pre-school and school are now relied upon to play a greater role in caretaking, education, and socialization. In neighbourhoods where "latch-key kids" are common, school may be the child's sole stable environment.

There have been many changes in the family over the past several decades.

- In 1986, 84 percent of Canadian families had an average of 3.1 persons.
- Remarriage or common-law relationships, with children from different families of origin, have resulted in the "blended" or "reconstituted" family. In 1986, 37.8 percent of common-law couples had children, up from 34.2 percent in 1981.
- 64.8 percent of married couples had children in 1986, down from 66.2 percent in 1981.
- In 1985, there were 14,346 employed single parents with pre-school age children in BC. In 1986 there were 1.16 million single parent children in Canada.
- Two income families are the norm in BC, with a combined average family income in 1985 of $40,506.
- 20 percent of families with children are headed by single women, an increase of 93 percent since 1971.
- The percentage of Canadian women over 15 who work outside the home increased 42 percent from 1971 to 1986.
- While part-time and full-time work increased in the 1976-86 time period, almost half of all working women earned less than $10,000, compared with 28 percent of men. Women employed full-time earned, on average, 64.9 percent of the average earnings of men.
- Lone parent families headed by a female account for 33.3 percent of all low income families. Employment earnings accounted for 64 percent of income sources for single female parents with government assistance accounting for 24 percent.
- The average single female parent income was $18,852 in 1986.
- The average single male parent income was $32,912 in 1986.

The development of children into healthy adults is a continuum, involving the child's relationships in the family and community. The concept of early critical periods is slowly being supplemented by a lifespan view in which the unique opportunities and hazards of each age are recognized as being important. At the same time as the structure of the family is changing, there is widespread agreement about what children need from the family to promote a healthy life. These include:

- a secure attachment to their parents
- a continuity of relationships with major caregivers
- early mental stimulation
- sufficient, appropriate and consistent structure in the family
- freedom from rejection, abuse, violence or chronic discord
- a sense of cultural values.

The Health Promotion Directorate of Health and Welfare Canada has developed a parenting program called *Nobody's Perfect* for parents struggling to provide a secure family environment for their children. The BC Office of Health Promotion has recommended that the program be implemented on a province-wide basis. The program should also be made available through schools for teenage parents.

Therefore, the commission recommends that:

1. the Ministry of Health and the Ministry of Education institute a province-wide program to implement the *Nobody's Perfect* program through schools.

The proliferation of day cares and pre-schools reflects the changing roles of women in society, the increase of single parent families, and the increased emphasis on early education and stimulation. There is evidence that high quality pre-school programs can affect both the short-term and long-term health and social status of children, but the most effective programs require significant resources to have lasting effects.

Therefore, the commission recommends that:

2. licensing standards for child care programs be based on increasing the social, psychological and physical functioning of children.

•*Poverty*

As stated in ***Public Policies for Health***, poverty has a profound effect on the risk of death or illness in adults and children. Poverty and the social and demographic conditions associated with poverty represent the most important factors in the rate of infant mortality and low birth weight children. Low birth weight has wide-ranging implications for future health.

> *We*
> *all know that children of poor homes*
> *have the worst health,*
> *and that poverty can often be the cause or consequence*
> *of ignorance and apathy.*
> *Indeed, health care of children often takes second place*
> *to the family struggle for economic survival.*
> HCP-125

A recent Ontario review of the effect of poverty on children concluded that:

> *the close association between poverty and risk holds for every component of risk – from premature birth to poor health and nutrition, from failure to develop warm, secure, trusting relationships to child abuse, from family stress to failure to master social skills.*
>
> Ontario Ministry of Community and Social Services, 1989 "Better Beginnings, Better Future: An Integrated Model of Primary Prevention of Emotion and Behavioural Problems"

Poor children are 40-50 percent more likely to be born too small, too soon, or with growth retardation. They are almost twice as likely to die before their first birthday, and are over twice as likely to suffer long-term disability and other health problems.

- The rate of early death among men living in the lowest income areas of Vancouver and Victoria is three times higher than that of men in the highest income areas.
- In 1985, more than one million children were living in low-income families in Canada. Children are twice as likely as adults to be fed by foodbanks.
- The overall poverty rate for families whose head of household is under 25 years of age has increased 50 percent from 1976 to 1986.
- Families headed by single female parents spent 48 percent of before tax income on basic necessities such as food, shelter and household operations. Single female parent families generally must choose between income assistance or joining the working poor.
- Court orders for family support are in full or partial default in 80-90 percent of cases.

The Social Planning and Research Council of BC has stated that the gap between basic income requirements for living and the income supplement available through the provincial program Guaranteed Available Income for Need (GAIN) represents a shortfall of 39 - 67 percent for families with children. For example, a single mother with a 16 year old son and 14 year old daughter received $1,040.66 a month in 1989 but required $1,698.45 a month for living, a shortfall of 38 percent. This problem is compounded by the increasing cost of housing and by GAIN not taking account of the fact that taking care of children of different ages requires different amounts of money.

Studies have also shown that high levels of unemployment and economic instability significantly increase levels of mental illness and have adverse effects on the physical health of the unemployed and their families.

The disparity in health among different cultural groups is also very important and, as pointed out in ***Native Health***, there are marked differences in mortality rates between Native children and children of non-Native Canadians.

Therefore, the commission recommends that:

3. welfare rates for families with children be increased.

•*Family Violence*

Our understanding of the extent of family violence in Canada is incomplete and inaccurate due to the variety of definitions used to describe it. Although the definitions vary, violence is almost always directed at the vulnerable: women, children and the elderly.

- The BC Ministry of Social Services and Housing investigates more than 32,000 complaints of child abuse and neglect annually.
- While Natives account for 3 percent of the Canadian population, 23 percent of the suspects and 22 percent of the victims of family homicides from 1974-87 were Native. Nearly half of all solved homicides involved a Native victim.
- Abuse of female partners occurred in all income groups, but was more common among those with low incomes and those aged 19-29.

Child abuse and neglect must be addressed in terms of the larger issue of family violence. Children subjected to violence, or exposed to chronic violence, face a high risk of failure in life. A recent report stated that children who have a history of abuse or severe neglect are more likely to have problems with depression, suicide and drug use. They are also more likely to be involved in criminal activities and violent crimes.

The cases of abuse seen by the authorities are increasing both in number and complexity. Drugs, alcohol and poverty play an important role in many of them.

While there are good medical indicators of physical abuse in children, sexual abuse is more difficult to detect; sexually abused children may only display behavioral changes. Improved medical, psychological and social assessments, and short-term and long-term interventions could decrease the continued victimization.

Therefore, the commission recommends that:

4. the province adopt the following targets and long term strategies to reduce the consequences of family violence:

Targets

a. Substantially reduce the number of children who are physically and/or sexually abused.

b. Reduce the long-term emotional effects suffered by children from physical abuse, sexual abuse, emotional abuse and neglect.

c. Improve professional competence in the area of family violence, including that of physicians, nurses, social workers, psychologists and psychiatrists.

d. Improve provincial statistics including data on the effectiveness of programs.

Strategies

a. Early detection in schools and day cares centres be augmented to prevent further abuse.

b. A coordinated provincial approach to child abuse, to include identification, treatment, and follow-up.

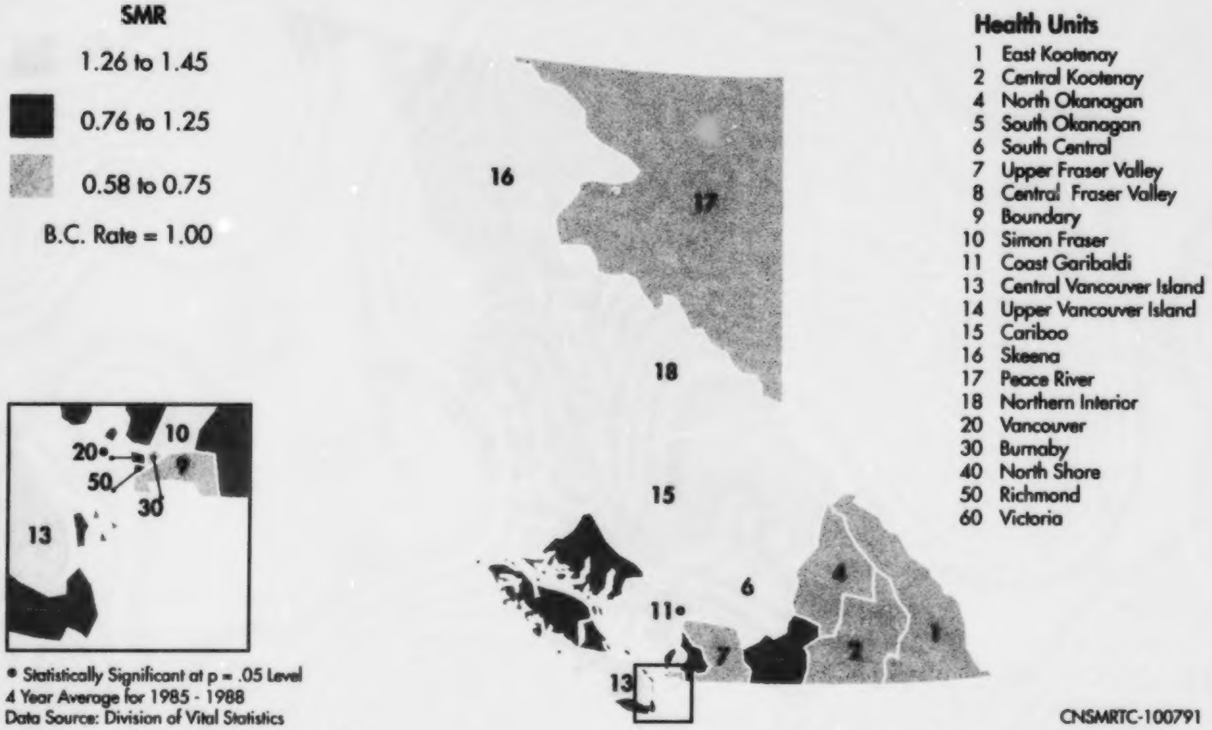
c. The establishment of a centre to provide leadership, and of functioning programs throughout the province.

d. Continuing education and training for professionals in the field.

e. A provincial family violence surveillance and information system.

Even though people are now aware that there's a big problem, there's still a denial of the kind of impact there is, and there's still not a recognition of the complexity of the kinds of effects that both sexual assault and family violence have.
SOC-307

BC INFANT MORTALITY RATE - BY HEALTH UNIT


SMR
1.26 to 1.45
0.76 to 1.25
0.58 to 0.75
B.C. Rate = 1.00
Health Units
1 East Kootenay
2 Central Kootenay
4 North Okanagan
5 South Okanagan
6 South Central
7 Upper Fraser Valley
8 Central Fraser Valley
9 Boundary
10 Simon Fraser
11 Coast Garibaldi
13 Central Vancouver Island
14 Upper Vancouver Island
15 Cariboo
16 Skeena
17 Peace River
18 Northern Interior
20 Vancouver
30 Burnaby
40 North Shore
50 Richmond
60 Victoria
16
17
18
15
6
11•
4
1
2
7
13
10
20•
50
9
30
13

• Statistically Significant at p = .05 Level
4 Year Average for 1985 - 1988
Data Source: Division of Vital Statistics

CNSMRTC-100791

Prepared by: Health Economics & Planning Branch, Ministry of Health

Map Source: Planning & Statistics Division, Ministry of Finance & Corporate Relations

The effect of violence in the media has been a subject of research and debate for a number of years. Some studies suggest that people who are directly exposed to violence, such as sexual or physical abuse, do engage in abusive behaviour as adults. Role modeling has also been shown to lead to higher levels of aggressive behaviour in children. And while the belief that exposure on a mass scale leads to a more violent society remains speculative, the interaction of social circumstances, values and sex role stereotyping suggests specific effects result from media violence. Pornographic materials reinforce stereotypes which contribute to violent and abusive behaviour.

The federal government reports that 37 percent of female and 36 percent of male children have been sexually abused by the age of 15. The Canadian Medical Association suggests that 25 percent of women and 10 percent of men were sexually abused by age 16.

The accuracy of these numbers is questionable, and they must be used with caution. Sexual abuse occurs – that is undisputed – and it has long lasting and complex consequences. But different definitions of child sexual abuse, different methods of measurement and estimation, different sources of information and populations studied all make it difficult to define actual numbers.

However, provincial programs for the treatment and management of children who have been sexually abused are inadequate, despite the government's initiatives. The government should establish and monitor standard guidelines for the whole province and produce an annual report which documents the needs of rural and remote BC.

Whatever the numbers, the extent of sexual abuse of children is far larger than previously estimated. And we must be careful that the current emphasis on child sex abuse does not intimidate caregivers and health care workers, the very people needed to deal with this problem.

Therefore, the commission recommends that:

5. the province
  a. request the Canadian Radio-Television and Telecommunications Commission to reduce violence in programs; and
  b. develop information programs encouraging parents to control children's choices of television programs.

The minister responsible for Women's Programs has established a *British Columbia Task Force on Family Violence*. We support this task force in its work and have made the public *submissions to this commission, and an internal analysis of them, available to the task force.

Live Births

The number of live births for every 1,000 births in BC has been relatively stable over the past several decades. Births continue to outnumber deaths in the population due to the women born in the "baby boom" years (1945 to 1965) now bearing children themselves; however, the fertility rate has declined to a point below the population replacement level of 2:1.

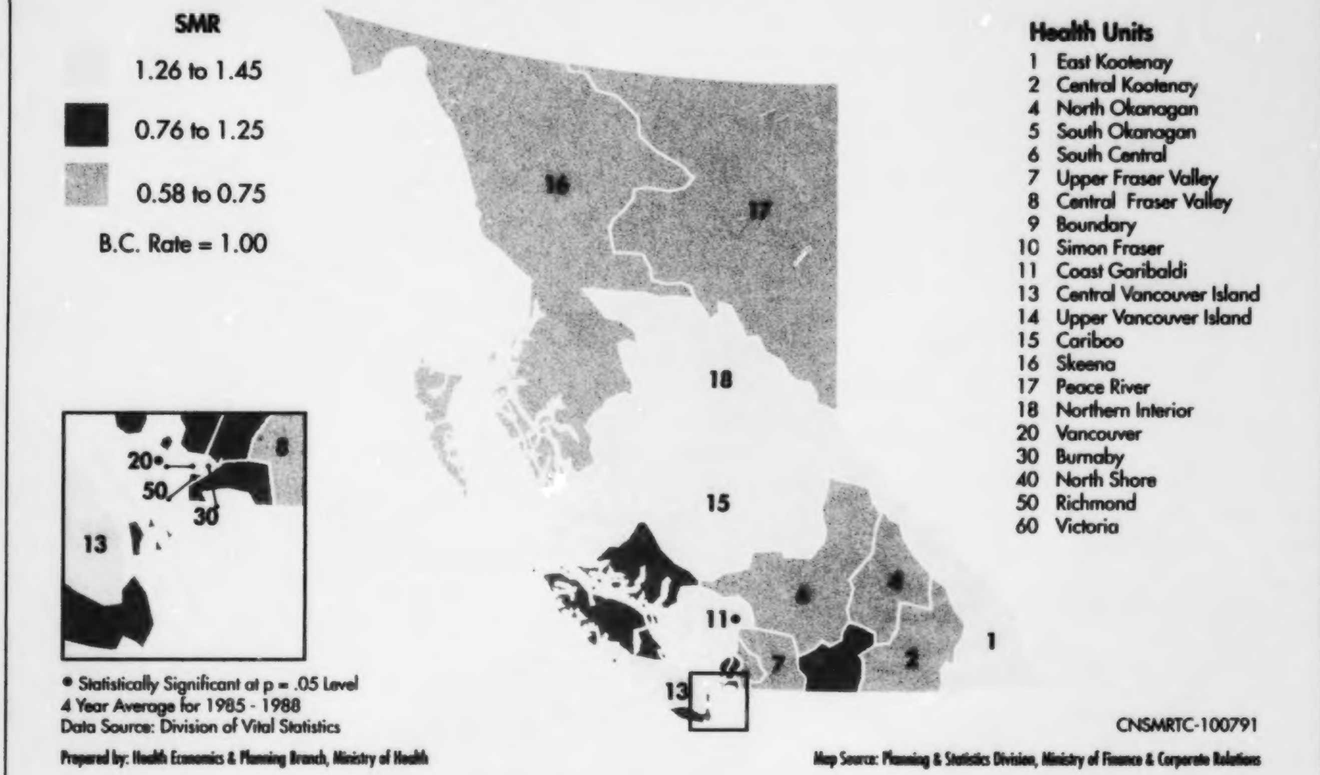
Infant Deaths

Children are most vulnerable to illness or death in the first 12 months of life.

- Infant mortality rates have fallen in Canada and BC since 1971. Improvements in maternal health, *prenatal care, socio-economic conditions, and quality of living may account for these declines.
- There were 344 infant deaths in 1989 in BC. Of these, 53 percent occurred during the first six days of life and 38 percent during the post-neonatal period (28 days to 1 year).
- Nearly 31 percent of deaths among infants less than one year old occurred to mothers 25 to 29 years old.
- Perinatal conditions and congenital irregularities account for 65 percent of infant deaths.

* GLOSSARY

BC PERCENTAGE LOW BIRTH WEIGHT - BY HEALTH UNIT


SMR
1.26 to 1.45
0.76 to 1.25
0.58 to 0.75
B.C. Rate = 1.00
Health Units
1 East Kootenay
2 Central Kootenay
4 North Okanagan
5 South Okanagan
6 South Central
7 Upper Fraser Valley
8 Central Fraser Valley
9 Boundary
10 Simon Fraser
11 Coast Garibaldi
13 Central Vancouver Island
14 Upper Vancouver Island
15 Cariboo
16 Skeena
17 Peace River
18 Northern Interior
20 Vancouver
30 Burnaby
40 North Shore
50 Richmond
60 Victoria
16
17
18
15
6
4
11•
7
2
1
13
20•
50
30
8
13
CNSMRTC-100791

• Statistically Significant at p = .05 Level
4 Year Average for 1985 - 1988
Data Source: Division of Vital Statistics

Prepared by: Health Economics & Planning Branch, Ministry of Health

Map Source: Planning & Statistics Division, Ministry of Finance & Corporate Relations

Infant mortality (deaths in the first year of life) is a good indicator of the hygiene and health conditions prevailing in a population. The reduction of deaths due to infectious diseases during the first year of life has concentrated deaths during the *neonatal period. A recent project in North Carolina linked birth and death records for a four-year period. The results suggest that more than half of the infant deaths studied could have been prevented through comprehensive prenatal and perinatal care, including nutrition, social support and education services combined with appropriate medical care. This has significant implications for health care costs and prevention strategies. To achieve any significant reduction in perinatal mortality, a reduction in the number of stillbirths and the number of deaths during the first six days of life would have to occur. This would mean improvements in prenatal medical care and maternal nutrition, and a reduction in maternal smoking and alcohol use. It would also mean developing a more accurate way of compiling information on prenatal care.

Therefore, the commission recommends that:

6. **the Vital Statistics Division improve the quality and quantity of information recorded on the physician's notice of live birth and the registration of live birth.**
7. **the Ministry of Health and the Vital Statistics Division develop the capacity to track prenatal care and evaluate quality of care.**

•*Low Birth Weight*

The principal hazard for the newborn is low birth weight (less than 2500 grams). Low birth weight results from In Utero Growth Retardation, premature birth, or some combination of these factors.

- Low birth weight is associated with about 75 percent of early neonatal mortality in Canada.
- In 1989, 5.2 percent of live births in BC were below 2,500 grams. This rate has remained virtually unchanged over the last 10 years.
- In BC, in 1989, 49 percent of infant deaths occurred in infants weighing less than 2,500 grams.
- Women 19 years of age or less had more low birth weight babies: 6.3 percent compared with 5.2 percent for all age groups.

In western countries, the causes of low birth weight include low socioeconomic status, the young age of the mother, unmarried status, lack of education, smoking, alcohol and other substance abuse, obstetrical complications, and a low level of prenatal care. Low birth weight is associated with:

- cerebral palsy
- seizure disorders
- congenital anomalies
- lower respiratory tract infections
- learning disorders
- behavioural problems
- complications of neonatal intensive care interventions
- increased *morbidity
- higher hospitalization rates
- emotional and financial stresses within the family
- marital instability.

Most of the social variables related to low birthweight are closely associated. In the case of teenage mothers and low socioeconomic origin, the association is quite strong. The potential consequences of a teenage pregnancy for this group include:

- incomplete education - 65 percent drop out of school and most do not return
- dependence on welfare - adolescent mothers account for 50 percent of aid to dependent families and many remain below the poverty line
- greater likelihood of childhood illness
- the parent is sometimes unable to assume responsibility.

Therefore, the commission recommends that:

8. **to ensure that all children have an adult who is responsible for them, the Superintendent of Family Child Services be empowered to appoint a person as advocate for an infant of parents who are minors.**

Social and demographic variables are important predictors for different birth outcomes in metropolitan areas. Interventions, such as prenatal programs targeted at specific neighbourhoods, should take advantage of any existing community social structure and referral patterns.

There are small variations among BC's health units in the low birth weight rate. A minimum target for all *health units should be the lowest average level achieved in the province with a provincial target of three percent. The importance of *health status indicators to the population's health is discussed in ***Public Policies for Health.***

• *Extremely Low Birth Weight Infants*

The successes of newborn care have created two new groups of survivors: very low birth weight infants, weighing under 1500 grams, and extremely low birth weight infants, weighing less than 1,000 grams. The *Neonatal Follow-up Program* of BC's Children's Hospital shows that survival for extremely low birth weight infants has increased from less than 10 infants surviving in 1975 to 58 in 1990.

It is,
in my view,
unethical
for our society to provide support
for these children
in the new-born period,
then not provide
after-care facilities for them
and
their families
into school age and beyond.
HOS-184

These infants spend approximately 104 days in hospital after birth at an average cost of $124,800 - $156,000 each. And survivors require a wide array of support services including medical, hospital, social services, respite and parent support, rehabilitation and special education services. The lifelong health problems (cerebral palsy, blindness, mental retardation) facing many of these infants raise both ethical and financial issues.

• *Congenital Anomalies*

After low birth weight, congenital anomalies are the most common cause of death in infants. In 1989, in BC, one in 20 live births had a major or minor congenital anomaly. There is no evidence, however, that rates are increasing or decreasing in Canada, and there has been no epidemic of congenital anomalies since the thalidomide epidemic of the early 1960s.

A recent study at Children's Hospital documented the outcome of children born with congenital anomalies. In general, children who had single anomalies did very well. The same can be said for about half of the children with multiple anomalies but normal mental function, identified early in prenatal life. However, a lack of coordinated care and planning is a major concern for this group. The other half of the group with multiple anomalies did poorly, with death rates of 40 - 60 percent. Survivors often suffer long-term disability.

Early identification and management of infants with congenital anomalies play an important role in reducing death, illness and disability. The development of intrauterine surgery and the early operative management of spina bifida are examples of medical interventions in this area. Screening can also provide parents with the choice of early termination of the pregnancy or allow them to prepare for the birth of a handicapped child.

• *Ethical Considerations*

The long-term consequences for the child, the family and the society able to save very low birth weight infants and those with congenital anomalies are complex. The use of new reproductive technologies contributes to the ethical issues confronting all of us. The Federal Royal Commission on New Reproductive Technologies is expected to address many of the issues in this area.

Therefore, the commission recommends that:

9. hospital ethics committees develop programs based on the long-term consequences for children, families and society of severely disabling conditions, and that this information be used to provide counselling when diagnostic screening establishes that a severely disabling condition exists.

10. abortion be readily available for those people who choose that option.

Perinatal Care

Targets:

- To reduce the provincial low birth weight rate to 3 percent.
- To reduce infant mortality by 25 percent.
- To reduce the number of days of hospitalization for newborns by 25 percent and infants beyond the newborn period by 15 percent.
- To reduce the provincial rate of teen pregnancy by 25 percent.
- To reduce the current rate of moderate to heavy alcohol consumption during pregnancy.
- To reduce smoking during pregnancy.

Strategies:

A regionalized system for reproductive care, the *BC Reproductive Care Plan,* is in place to provide education and support, but a number of submissions to the commission express major concerns about the system's effectiveness. Early identification and prevention programs, such as *Healthiest Babies Possible* and the *Pregnancy Outreach Projects* are insufficient and are not coordinated.

Therefore, we are suggesting the following changes.

- Establish reproductive committees within each community to coordinate services including *health promotion, prevention and management.
- Establish clear definitions of the different levels of care and the responsibilities of professionals providing service.
- Incorporate health promotion and encourage communities to take action.
- Establish a way to measure and monitor the quality and effectiveness of the reproductive care program on a population basis including creation of a perinatal information database.
- Provide ways to monitor the long-term effect of perinatal care in terms of health and developmental problems.

* GLOSSARY

Antenatal Care Programs

The BC government funds eight *Pregnancy Outreach Projects* across the province. These programs identify pregnant women who might have low birth weight infants or other poor pregnancy outcomes. Clients include:

- women who are substance abusers
- women with poor previous birth outcomes
- women with poor nutritional status
- women with inadequate weight for height
- women with low gain before and during pregnancy
- women who are obese
- women who follow a strict vegetarian diet
- women with susceptibility to infectious diseases, especially rubella.

And
to treat antenatal care
- which seems to me
to be essential
to produce healthy
children -
as being an add-on,
not a necessary part
of health care,
doesn't seem
to be sense.
SOC-031

The eight *Pregnancy Outreach Projects* serviced 300 clients, nearly half of them Native mothers, during a one-year period at a total cost of $220,000 or $733 per client. These programs are generally effective but more study is required.

The Vancouver Health Department also runs a similar program, *Healthiest Babies Possible*, which employs three dietitians, three lay counsellors and three part-time interpreters. Home visits and clinic visits are made with diet supplementation included in the program. In 1990, only 20 of the 375 low birth weight babies born in Vancouver were in the *Healthiest Babies Possible* program. However, the program lacks an outreach component to identify high-risk women. *Baby's Best Chance*, a ministry production, is available throughout the province in booklet and video format, but the video is available only in English, making it inaccessible for high-risk ethnic populations.

The *Women, Infants and Children* (WIC) program in the United States appears to have mixed results. The program includes food supplementation, nutritional counselling, and on-site referral for health services. The Montreal *Diet Dispensary* has provided assessment, counselling, supplementation and referral to urban, high-risk, low-income women since 1963. Studies suggest that this program reduces or at least maintains the rate of low birth weight to levels comparable to those in the general population. The *Healthiest Babies Possible* program suggests the same results.

Therefore, the commission recommends that:

11. prenatal education packages and videos be developed in the major language groups in BC.

A review of prenatal intervention programs in the United States and Ontario suggests criteria which appear to improve outcomes.

- Clearly defined goals and an explicit statement of the program components and how they effect changes in birth outcomes. For example, reducing consequences related to problems occurring in the third trimester requires increased prenatal medical visits during the third trimester.
- A continuous system for the assessment of risks with a standard system of classification and nomenclature to reduce the current confusion.
- An accurate dating of pregnancy to detect intrauterine growth retardation, and to avoid prematurity through non-emergency caesarean section.
- The detection and management of behavioural risks. Effective interventions

for smoking, alcohol and drug abuse, and nutrition deficiency should be provided. Note: The use of prenatal screening for potential adverse birth outcomes, such as maternal stress, is not warranted without further evidence.

- Prenatal education and counselling for pregnant mothers, often on a one-to-one basis, regarding pregnancy, nutrition, general hygiene and lifestyle. Self-help instruction and support is also useful.
- Lay counsellors from the ethnic and cultural community who provide information to women, assist in follow-up, interpret information, and ensure that services are culturally appropriate. Non-professional community health aides, as described in ***Multicultural Health***, may improve women's participation in and compliance with prenatal care programs and regimes. Often these workers act as outreach workers and provide continuity of care. They are drawn from the same cultural or ethnic background as high-risk populations and are able to provide basic education and support throughout the pregnancy.
- Prenatal services must be available in communities and neighbourhoods where high-risk women live. They must be open during non-traditional hours and must be provided in a culturally and socially acceptable manner.
- Health care and social service providers at the hospital and community social service level must be actively involved in developing and maintaining referral networks. Without such involvement, any program, no matter how well organized, will fail.

A recent survey shows physicians are a primary source of referral for high-risk mothers to public health. Unfortunately, there appears to be poor coordination in many parts of the province between physicians and organized prenatal programs.

Studies of births involving midwives generally show improved birth outcomes. Midwives spend more time in counselling and patient education with clients, assist them to keep appointments with physicians, and reduce communication problems for patients whose educational or cultural backgrounds make it difficult for them to get obstetrical services or to use them appropriately when they do make contact. We have discussed the issue of using midwives in BC more fully in ***Health Care Personnel.***

Therefore, the commission recommends that:

12. the Ministry of Health

a. expand prenatal nutrition and outreach programs to more communities;

b. establish criteria for the active development and management of a referral network and outreach programs;

c. in consultation with the BC Medical Association and the College of Physicians and Surgeons, develop protocols for the referral of high-risk mothers to prenatal outreach projects, and monitor physician compliance with the protocols;

d. require community involvement in the development of outreach projects;

e. urge alcohol and drug programs to refer high-risk clients to prenatal outreach projects; and

f. locate prenatal projects in communities and neighbourhoods where there is a high incidence of low birth weight infants.

Follow-up Programs for High-Risk Infants

Approximately 5 percent of the children in BC have a disability which impairs their lives. We know that comprehensive services can reduce social isolation among these children and help them become capable of independent lives. But there are waiting lists for essential services such as speech and language therapy, and there is very little information with which to plan these services. As we have stated in ***Services to People with Disabilities*** providing services is often the responsibility of many different ministries and agencies within any one community. This leads to poor organization and a lack of community control over health care services to high-risk and disabled children and to the general public.

Therefore, the commission recommends that:

13. the Ministry of Health and the Ministry of Social Services and Housing
   a. assign the responsibility for providing services to one ministry or agency; and
   b. develop travelling rehabilitation teams for underserviced rural areas.

Breast Feeding

Breast feeding is generally promoted as the best way to immunize a child and to provide it with the necessary nutrition. Breast feeding is most common among older mothers, those with formal educations, higher income levels, supportive social networks, and who are non-smokers.

Only 30 percent of new mothers continue breast feeding after leaving the hospital. However, studies suggest that approximately 50 percent of mothers who stop breast feeding during the first six weeks would continue if they had received appropriate education at the hospital.

The distribution of industry marketed gift packs of formula to breast feeding mothers reduces breast feeding. Health and Welfare Canada and the Ministry of Health "strongly encourage" hospitals to comply with the World Health Organization's *International Code on the Marketing of Breastmilk Substitutes,* which recommends that no advertising or free samples be distributed in hospitals. Grace Hospital, St. Paul's Hospital, Lion's Gate Hospital and the Greater Victoria Hospital Society currently have formal policies incorporating this recommendation.

Therefore, the commission recommends that:

14. the Ministry of Health
   a. require all hospitals to adopt the World Health Organization's *International Code on the Marketing of Breastmilk Substitutes;*
   b. require all hospitals and public health departments to adopt the World Health Organization's *10 Steps to Successful Breast Feeding* and develop joint programs; and
   c. determine the number of mothers who have attended hospital or public health department programs on breast feeding and annually publish the results for each hospital and public health department.

Deaths and Disabilities Due to Injuries

Deaths: Injuries are the leading cause of death (32%) in children and youth in BC. The most vulnerable to injury–related deaths are children less than 4 years of age and youth 15 - 19 years old. This is comparable to the Canadian average for each of the age group categories. However, Canada's injury death rate is among the highest of six western nations, second only to the United States.

Injuries: For every injury-related death, 45 injuries require hospitalization, 1,300 require emergency treatment, and an unknown number result in a visit to a physician or a clinic. Injuries and poisoning represent the third leading cause of hospitalization for children and youth.

In a recent study of 54 children who had suffered severe multi-system injuries, 62 percent had persistent physical handicaps, 59 percent had speech and emotional problems, 44 percent had deficits in attention, memory or learning, and 80 percent attended special education classes. The proportion of hospitalizations versus deaths varies by age group.

The most common injury-related causes of death in children and youth are: motor vehicle accidents (MVAs), bicycle accidents, pedestrian accidents, drowning accidents, and house fires. While the number of childhood poisonings has decreased with time, one of the suggestions received by the commission would be simple and not costly to implement.

> *At the present time certain hospitals in BC are designated as poison control centres, with St. Paul's Hospital, Vancouver being designated as the main information and resource centre for the province. This is an unwieldy and frequently very inefficient method with valuable time being lost in cases of serious poisoning.*

> *A 1-800 number for the entire province would refine the system, giving immediate access to the most knowledgeable resource people, and give citizens of the province one number to remember wherever in the province they may live...*
>
> HCP-235

Therefore, the commission recommends that:

15. the Ministry of Health implement a 1-800 line to St. Paul's Drug and Poison Information Centre.

MVAs are the leading cause of unintentional injuries resulting in deaths or hospitalizations: ***Substance Abuse*** points out that alcohol is associated with about 60 percent of motor vehicle injuries.

Estimates of the cost are difficult to come by due to the variety of procedures and services used. In Quebec, the cost of care for those injured in MVAs alone is estimated at $70 million annually. This estimate does not take into account the enormous cost of the number of potentially productive years of life lost.

> *...you've got a young person with a very severe head injury, who's going to be a care problem for the rest of their lives, and heaven knows, they may live sixty or eighty years.*
>
> HCP-020

Effective Interventions

Any strategy to reduce injuries among children and youth must be broad-based and include education as well as government legislation.

The comparatively high rate of injury fatalities in children and youth requires programs which are age-specific. However, very little is known about the risk taking behaviour of adolescents and, even with accurate knowledge of their dangers, children and youth frequently and repeatedly engage in high-risk activities.

The Vancouver Health Department ran a school injury surveillance system from 1983 to 1989. During 1989, 1426 injuries were recorded. Increased playground surveillance and changes in playground equipment would reduce injuries among elementary levels, while increased emphasis on occupational safety practices in secondary school workshops and changes in sports activities would reduce the number and severity of injuries among secondary school students.

St. John Ambulance has developed a first aid education course which has been shown to reduce the number and severity of injuries by one half among grade nine students.

Therefore, the commission recommends that:

16. the Ministry of Education implement
  a. an injury surveillance system in schools which will include the school grounds and areas immediately surrounding the school; and
  b. school safety and first aid courses in elementary and secondary schools.

17. the Ministry of Health develop a province-wide emergency unit injury reporting system based on national standards developed by the Canadian Hospital Information Reporting Program.

Public policy can be directed at individuals or at agents of injury. Some examples are: raising the drinking age; raising the driving age; the compulsory use of child car restraints and bicycle helmets; and safety standards for recreational equipment and automobiles.

Therefore, the commission recommends that:

18. there be stricter enforcement of seat belt regulations and speed limits on highways, and that there be public education to encourage compliance.

19. the BC Health Research Foundation fund research into programs to reduce the number and severity of injuries.

20. the province adopt the following injury prevention targets:
  a. reduce traffic fatalities by 25 percent by the year 2000;
  b. reduce the incidence of drowning fatalities and injuries by 25 percent by the year 2000;
  c. reduce injuries caused by fire and flames by 25 percent by the year 2000; and
  d. reduce injury-related utilization of medical services (emergency room, hospital, physician visit) by 25 percent by the year 2000.

Nutrition

We received a number of submissions concerning malnutrition and hunger among pre-school and school aged children. A recent review of Canada's nutrition guidelines recognizes the effect of the changed family on eating patterns and nutritional intake, and on physical activity in maintaining appropriate body weight for age. The report points out that the health of 5 to 25 percent of school age children is at risk due to poor eating practices or poor access to nutritious food. We think that there is adequate support for the implementation of school lunch programs.

Therefore, the commission recommends that:

21. the Ministry of Education implement a provincial school lunch program.

22. the Ministry of Education ensure that educational programs for nutrition and physical health be included in the *Learning for Living* program.

Dental Program for Children

Water fluoridation is the best preventive method available to reduce dental caries in a population. Where water fluoridation is not possible, dietary fluoridation, mouth rinses, and toothpaste should be used instead. Dental health may be improved by increasing the resistance of teeth to decay through changing dietary practices, and changing oral hygiene behaviours. The long-term benefits are evident in the significant reduction of dental caries among children.

Therefore, the commission recommends that:

23. the Municipal Act be amended to require fluoridation of all community water supplies.

The commission has been told that the Vancouver Health Department operates a successful school dental program with prevention as the primary focus. Certified school dental assistants teach children oral hygiene, and supplementary fluoridation in the form of tablets is encouraged. Children whose parents cannot afford a private dentist receive treatment from the dentists on staff at the health unit. The Peace River Health Unit has provided treatment for some children on the condition that the child's family adopt good oral hygiene practices.

Therefore, the commission recommends that:

24. the Ministry of Health fund prevention programs for improving the dental health of children.

Sexual Activity

Sexual activity among Canadian adolescents is estimated at 18 percent among 15 year olds and 66 percent among those 19 years old. Most of this activity is unplanned and sporadic, resulting in approximately 4,000 teenage pregnancies each year. Of these pregnancies, approximately 40 percent are aborted. While the total number of abortions and births compared with the total number of teenagers does not tell the full story of adolescent sexuality, it is a statement about the failure of our social, educational and health policies.

Comprehensive school sex education programs appear to lower the rate of teenage pregnancies, and the availability of contraceptive devices does affect pregnancy rates. Condom vending machines in public places, especially schools, laws which protect physicians who prescribe contraceptives without parental consent and the presence and community acceptance of advertising of contraceptives are all associated with lowering the rates of teenage pregnancies.

In one school that I was in this year, in the early part of the year, they went through a thirty-five pound pail of peanut butter in recesses, doling out to children on stale bread. There are a lot of children out in those schools who are hungry.
SOC-079

Besides the risk of pregnancy, sexually active adolescents run the risk of acquiring a sexually transmitted disease (STD). Chronic chlamydial infection, the primary preventable cause of sterility in women, is particularly troubling as young women and women using oral contraceptives are most susceptible to it. If chlamydial infection is transferred to an infant at birth, it leads to infant pneumonia, and often premature death. The ulceration of the cervix by chlamydial infection also increases the risk of other STDs, including HIV. Routine screening for chlamydial infection is not carried out, even though cost-effective programs are available.

While comprehensive sex education programs in schools have been found to be effective, a significant proportion of adolescents are not in schools. Many of these teenagers are at risk due to lifestyle, socio-economic status, ignorance of the health care system, and negative relationships with parents, social workers, police, and other social service agencies. Education about HIV, in particular, is a responsibility of the government, especially in view of the fatal consequences of ignorance about this disease. HIV and AIDS are discussed in more detail in ***HIV and AIDS.*** Strategies concerning sexually transmitted diseases are discussed in ***Public Policies for Health.***

Therefore, the commission recommends that:

25. the Ministries of Health, Social Services and Housing and Education jointly fund youth health clinics throughout the province.

26. the Ministry of Health develop a screening program for chlamydial infection for high risk youth.

27. condom vending machines dispensing latex condoms be placed in both male and female washrooms in high schools throughout the province.

Mental Health Services

In 1990, the federal government report on the state of mental health services for children in Canada, *Foundation for the Future*, revealed that:

- Mental disorders are more common in adolescents than in younger children, and in males than in females.
- Mental disorders are more common for children living in urban environments, and for those from lower socio-economic backgrounds.
- Behavioural disorders (e.g. conduct disorders, attention deficit disorders) are more common than neurotic disorders.
- Behavioural disorders are more frequent in males, while girls are more likely to exhibit neurotic disorders.
- Fifty percent of the children diagnosed with a conduct disorder continue to have problems in adulthood. They are also likely to have problems with depression, alcoholism, drug abuse, suicidal tendencies and psychosis.

- Children diagnosed with an attention-deficit disorder are more likely to have academic problems, alcohol and drug abuse problems, and contact with the legal system.
- Children from single parent families, families on social assistance, and families from subsidized housing, children in the care of child welfare systems, physically abused and neglected children, victims of sexual abuse, and children living in areas of overcrowding are at high risk of mental illness.

According to the Ministry of Health, 6,700 children and youth, about 50 percent of all cases of adolescent mental illness, were seen at community mental health centres in 1989/90. The remaining cases were handled through contract agencies. The province claims that 20,000 children and youth have severe mental and emotional problems but only 33 percent receive treatment. Rates suggest that the number of children requiring but not receiving help may be much higher.

In BC, the mental health services for children and youth have been described as mismanaged and fraught with bureaucratic barriers to accessibility. It is clear from government documents and funding initiatives that, similar to the situation of adult psychiatric patients described in ***Mental Health,*** children's mental health has not been a priority. In fact, it is only recently that new and more concerted initiatives have been developed to address the lack of programs in this area. Some of the previous and planned initiatives include:

- an eight bed addition to the Maples Adolescent Treatment Centre in Burnaby for short term respite, inpatient assessment, and community case planning
- funding allocated to child and youth services to provide treatment for children with multiple problems
- dedicated funds for court ordered assessment and treatment of young offenders
- $3 million from the budgets of five ministries to provide community-based treatment for sexual abuse victims and young sexual offenders
- improved services to remote and rural areas for assessment and treatment, and training of local practitioners
- the implementation of travelling consultation teams and psychiatric outreach
- the hiring of hospital liaison workers to provide suicide intervention in 12 communities with psychiatric units in general hospitals.
- the allocation of 12 community mental health staff and $800,000 to improve coordination in treatment and follow-up.

At the provincial level,
as well,
we find that
there is a lot
of lip service
given to children
and
youth services,
but not much action.
There is
a mental health plan for adults
that has been
worked on for the last 6 years -
it specifically
excludes children and youth.
MUN-027

Hospital Use by Children and Youth

There is very little accurate information on the use of hospitals by children and youth. The best information comes from hospital discharges.

- On average, children hospitalized for more than three months account for nearly 13 percent of all child/youth bed days. Hospitalization among children with a defined chronic condition represents 22.4 percent of patient days.
- In 1987/88 there were 32,574 procedures performed on children aged 0-14 years. The majority (53%) were performed on a daycare basis. One-third of all procedures were performed at Children's Hospital; most cases were related to prematurity. The remaining two–thirds were performed at centres throughout the province. Hospitalizations were generally due to central nervous system abnormalities, congenital abnormalities, or mental health problems.
- Chronic neurological or respiratory conditions were the most common chronic conditions.
- A trend toward an increased number of daycare procedures has made little change in the overall number of procedures performed.
- 48 percent of prolonged patient stays were in a *tertiary hospital.

Once again, we find ourselves in need of more information to identify who these children are, why they are being admitted to hospital and whether there is any other way we can help them.

NATIVE HEALTH

Before I had such a long chronically ill list,
about 12 years ago, I used to go in
and sometimes have lunch with the elders
and sit with them, learn about different problems
that were bothering them... and learn myself
from their vast knowledge. But it was at least
an hour to be social, and to be polite.
In our culture it's rude to roar into someone's house,
and say: "Could I have your pill box?",
fill it and run out.
I can remember a lady who's 90 now,
she's in the hospital now, but we would slip away
and go up to Charlotte and get an ice cream cone.
She liked soft ice cream. It was a big outing,
it made her feel better. Or we would go down the coast
with another lady, that's very knowledgeable
in herbal medicines, and pick some plant
when it was in season.
That's what makes them feel good,
gathering food, gathering medicines,
being with their friends. That's changed
in the last three years, it's been very bad.
NAT-005

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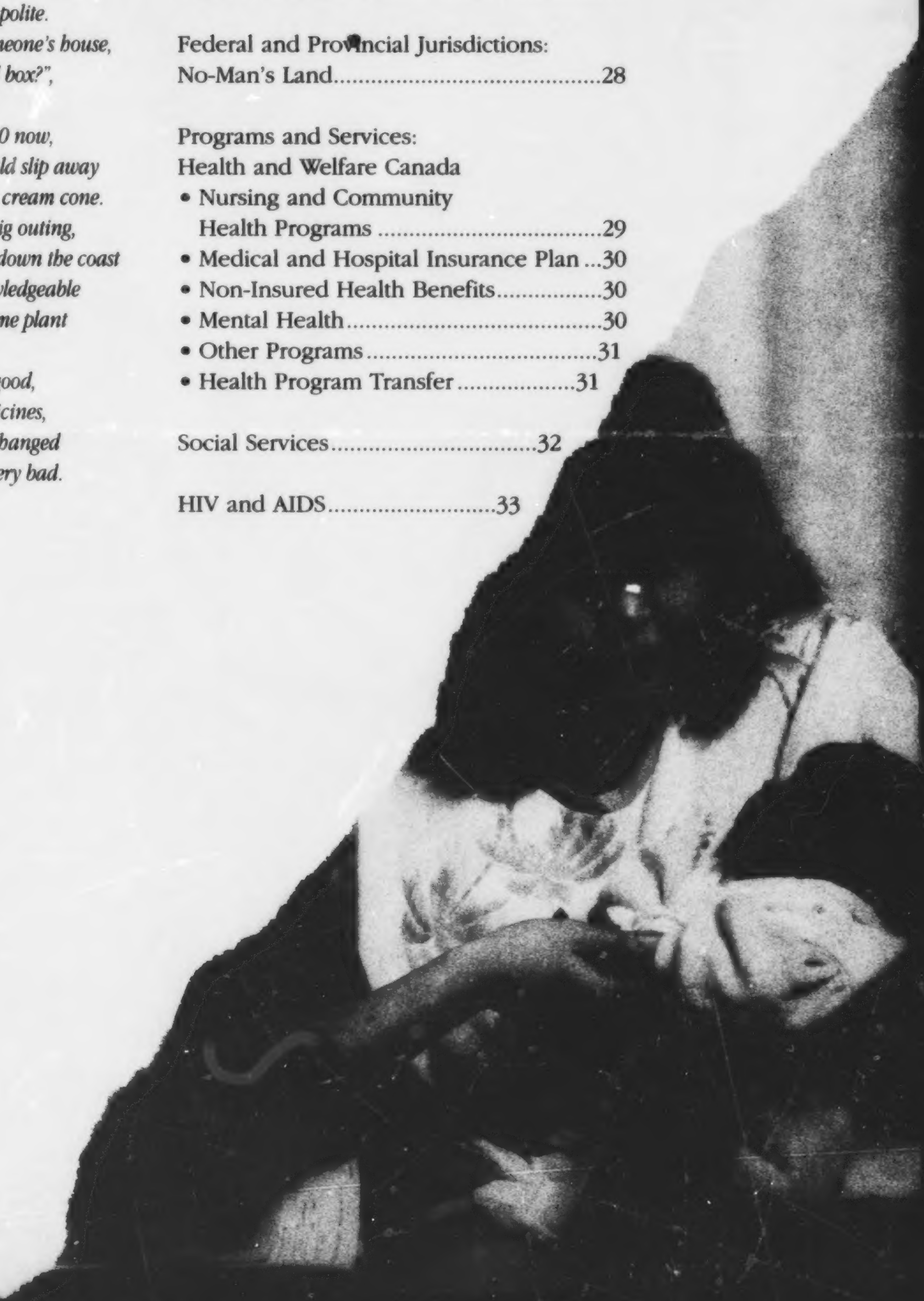


The Population

Before Europeans arrived, the population of the province was approximately 105,000, 40 percent of the total Native population of Canada. By 1929, the number of Natives had fallen to 22,000 and it was not until 1939 that the BC Native population began to increase.

According to the 1986 Canadian Census, there were 711,725 Canadians of Native origin, 40 percent of whom were Registered Indians, the remainder being Inuit, Metis and non-status Indians. The 1986 Census included Native peoples on and off reserves, but approximately 6 percent of the reserve population was not enumerated and the under-enumeration of the off-reserve population has never been accurately estimated.

The 1986 Census was also unable to fully estimate the effect of the 1985 Act to Amend the Indian Act, formerly Bill C-31 (1985). However, it was anticipated that by 1990, a further 90,000 Registered Indians would be added to the Native population by the Act. The effect of this addition is difficult to establish, since many of the Native people who regain status will not have the right to band membership and, therefore, will not have residency rights on reserves. Many of the applicants under the Act are middle-aged, well-established in urban areas, and have no desire to move to a reserve at this time in their lives. However, as old age approaches, many may wish to return, creating a demand for geriatric services not now available on reserves.

Today there are 80,742 Registered Indians in BC, representing six major linguistic groups. These groups include approximately 30 distinct languages, with English the principal language for 90 percent of the population. Four of these linguistic groups account for more than 40,000 people; nearly half of those people 65 years old and older speak a Native language at home, rather than English, creating a communication problem for the elderly.

In 1988, 84 percent of the 78,000 status Indians in BC were under 45 years of age and half were under 25. This is reflected both on and off the reserves, with the off-reserve population having a slightly higher proportion of people between the ages of 25 and 44. Compared with the total Canadian population growth rate of 0.8 percent, the annual growth rate of the status Indian population has been around 2.19 percent to 2.36 percent. Applicants under the 1985 Amendments to the Indian Act are expected to increase the status Indian population beyond the predicted growth rate.

While 62 percent of Registered Indians in Canada lived on reserve, BC had the lowest percentage at 54 percent. Although females outnumber males in the total Indian population, more males live on reserves. The lack of economic opportunities on reserves forces many young adults, but especially females, to leave their communities. Family size on reserves was 20 percent larger than off-reserve families. Of the 6,680 families on BC reserves, 23 percent were lone parents compared with 31 percent single parents living off reserve.

Slightly less than one-third of Registered Indians were employed in 1986, compared with 57 percent of the general population in BC. Twenty-two percent worked in primary industries – fishing, trapping, forestry – while 55 percent were employed as managers, office personnel, sales and service employees, and in the construction and transportation industries.

The average annual income for individual Registered Indians was $10,200, compared with $18,700 for the general population. Off-reserve Registered Indians had average incomes of $10,800 while on-reserve Indians averaged $9,800. Government transfer payments were the major source of income, more so for on-reserve than off-reserve Natives.

Housing conditions on reserves are poor.

- Nearly 16 percent of private dwellings on reserves had more than one person per room compared with 1.5 percent for the BC average.
- Central heating was absent in 38 percent of on-reserve private dwellings compared with 6.5 percent in the general population.
- Water and sewer facilities have been upgraded recently to the point where the majority of houses on reserves have water and sewer connections. However, the number of households and communities which still lack adequate facilities, a problem for many British Columbians that is more fully described in ***Public Policies for Health***, is difficult to determine.

Basic care and nutrition are compromised for both adults and children, particularly mothers and infants, when people are overcrowded in unsafe living conditions. Such conditions contribute to poor health among the Native population and there is considerable need for alternative child care support, and income and nutrition supplementation.

In 1986, 30 percent of Registered Indians had at least high school education compared with 60 percent of the general population. This lack of education limits employment opportunities and forces a continued ghettoization of the Native population. The circle of poverty, lack of education, under-employment and poor health, drives a dependence on social support that contributes to low self-esteem, family and community disorganization, drug and alcohol abuse, physical and sexual abuse, and high rates of suicide. The very living conditions in these ghettos increase the probability of death due to house fires and infectious diseases.

Therefore, the commission recommends that:

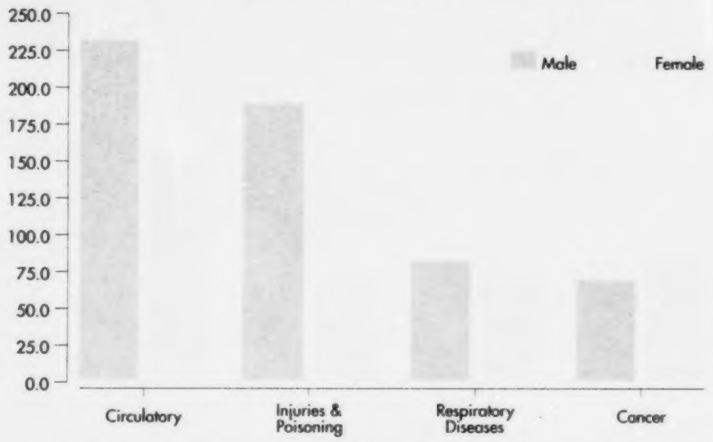
1. **school boards work with Native communities to increase the percentage of Native children who complete high school to the same level as the average throughout British Columbia.**
2. **the province support job training programs developed by Native communities.**

*Their *Health Status*

The health of Native British Columbians reflects their overall social and economic status. Their lack of access to properly integrated health and social services is an additional contributor to poor health.

However, the current information on Native health and the conditions which affect it are not adequate for planning and policy purposes. Native populations, after years of being studied, are reluctant to participate in social surveys, including the Canadian Census, as they have had no control over what information is gathered or how it is used. Addressing the health status of the Native people of BC will require treating the issue of control of data collection as a priority.

We have continuously expressed our concerns regarding the quality, the mandate and the management of the delivery of medical programs.
NAT-009



FOUR LEADING CAUSES OF DEATH AMONG NATIVES IN BC, 1987
(age standardized death rates; per 100,000 population)

Source: Vital Statistics, BC Ministry of Health, compilation by Dr. Peter Riben, Department of Health Care and Epidemiology, UBC

Therefore, the commission recommends that:

3. the Chief Native Advisor, Native Health, in consultation with the Native community, develop an information system to measure the *health determinants and health status of Native people.

Life Expectancy: Although the life expectancy of Native peoples has improved over the past 15 years, it is still eight years less than that of the general population.

Infant Mortality: Neonatal deaths among Native infants (0-28 days) are higher than the general population, and post-neonatal deaths (28 days to one year) are also higher. From 1982 to 1985, the total infant mortality rate for Natives in BC was 21.8 percent, compared with 8.9 percent for the general population.

The high incidence of alcohol abuse, smoking and other drug abuse, inadequate or non-existent pre- and post-natal care, poor nutrition and poor housing all contribute to the high rate of infant deaths. It could be reduced by improving *prenatal conditions affecting the mother and the foetus, and those conditions which affect infant health, such as respiratory diseases.

Causes of Death: Accidents, poisonings and violence, including suicide, account for more than 33 percent of deaths among Native people compared with 9 percent in the general population. The high (90%) level of immunization has virtually eliminated vaccine-preventable diseases among reserve residents.

In BC, the rate of Native deaths:

- from motor vehicle accidents is double the provincial rate
- from fires is more than 12 times the provincial rate
- from drowning is almost seven times the provincial rate
- from exposure, primarily due to traditional trades such as trapping, is 24 times the provincial rate
- from falls is more than one-and-a-half times the provincial rate
- from suicide is three times the provincial rate. Native men, 20 to 24 years old, are five times more likely to commit suicide than other Canadian men of the same age. The suicide rate for BC Native people ranks fourth highest among the provinces and territories, whereas the suicide rate for the general population ranked third lowest.

A 1987 needs assessment – conducted by the Ministry of Labour and Consumer Services, Alcohol and Drug Programs – found that alcohol abuse was common in 93 percent of Native communities and drug abuse common in 81 percent. In Vancouver, 40 percent of the registered users of the needle exchange program are Native. Their involvement in the intravenous (IV) drug culture, and their consequent risk of exposure to HIV infection, have serious implications for the transmission of AIDS within the urban and reserve populations. As discussed in ***HIV and AIDS*** the conditions for the rapid spread of HIV infection – high rates of sexual abuse, alcohol and other drug abuse, and high rates of sexually transmitted diseases which increase the risk of HIV infection – already exist in many isolated Native communities. Immediate public health policies and programs to reduce the potential for HIV infection within the Native population are critical to the province's health status.

Facilities are also needed to provide services for youth, both in treatment and detox. Native youth are currently placed in adult facilities, depending on space, but staff are adult-oriented and find it difficult to respond to their special needs. The only treatment facility for Native youth in the province is Peak House in Vancouver, which targets *highly* motivated youth and their families, thereby restricting its service delivery.

Therefore, the commission recommends that:

4. alcohol and drug programs be developed for Native youth, women and IV drug users, and needle exchange programs be supported.

Causes of Illness: Native people suffer from a myriad of ailments generally associated with low social and economic status. The general health status of the Native community, in some isolated reserves in particular, resembles that found in third world countries.

Native people suffer from diseases which, for the most part, are preventable by relatively unsophisticated means. For example, while infectious diseases have declined dramatically in the general population, Native deaths due to new or reactivated tuberculosis are ten times the Canadian average. Respiratory problems are a major cause of hospitalization among Native children and a recent BC study of respiratory problems among children found significant differences between Native and non-Native children, indicating the pervasive effect that poverty, poor housing and inadequate nutrition have on health.

Genetic conditions also have significant effects on Native health. A study by the BC Ministry of Health which examined single Native births suggests that heavy birth weights in Native children, and a higher than average level of diabetes in the Native population, may be a result of a genetic predisposition to store calories as fat. While this may be efficient when food is limited, in today's society, with easy access to high caloric food supplies, it often results in obesity and glucose intolerance.

In BC, the 1983-84 *hospital separation rate (discharges including deaths) for Native people was 40 percent higher than for the general population. It should be noted, however, that the number of inpatient days for Native people was only 16 percent higher. This discrepancy may be attributed to frequent admissions for short periods of time.

Currently, the health needs of Native communities are determined by outside agencies, usually without Native input or control. But if British Columbians are to address these serious health issues, governments must relinquish much of the control over how and what services are delivered, and real partnerships must be forged between health care providers and Native communities. Culturally appropriate programs which meet the needs of the community and are controlled by the community must be funded, designed and implemented.

Unless we settle the lands claim issues, address poverty, social and cultural and environmental problems, cut the strings of government dependency and allow for true equality, you'll simply continue to provide expensive bandaid answers.
PRO-129

Therefore, the commission recommends that:

5. **the premier direct all ministries to address the health and social and economic concerns of Native people.**
6. **the government consult with and involve Native people in the design, development and implementation of programs, services or policies for Native people.**
7. **the office of the Chief Native Advisor for Native Health be made into a separate branch within the Ministry of Health with its own assistant deputy minister.**
8. **the planning and implementing of housing, employment and education programs be the responsibility of Native people.**
9. **the Ministry of Health support the development of Native-controlled health services, including services to urban Natives.**
10. **provincial *health units provide cross-cultural staff training and hire Native staff.**

The new Native Health Branch should increase coordination and communication among the ministries of government and the branches within the Ministry of Health. It must not create a separate health service for Native people. The expectation is that a Native Health Branch could increase the joint funding of programs with other departments and ministries. The branch should also develop and maintain a database on Native health and the conditions affecting their health.

Federal and Provincial Jurisdictions: No-Man's Land

The provincial government maintains that it is the federal government's exclusive jurisdictional obligation to provide services to Native people living on reserves. The federal government maintains that, under Section 92(7) of the Constitution Act, 1867, Native health falls completely within provincial jurisdiction, and that the costs of providing these services to all Native peoples are included in the calculation of federal transfer payments to the provinces. The federal government contends that its support of health services to Native people is a matter of custom and policy, and is not the result of any constitutional or treaty obligation.

The federal government also insists that Section 91(24) of the Constitution only applies to Registered Indians on a reserve, and therefore refuses to provide services to Metis or non-status Indians. Status Indian health programs are managed by the Medical Services Branch (MSB) of Health and Welfare Canada.

While it would be more efficient to have one jurisdiction responsible for Native health care, this would release the federal government from its responsibilities and raises two concerns:

- the federal government would not transfer adequate funds
- the province would not meet its obligations.

Many Native organizations and tribal councils are apprehensive. They argue that only the federal government has the jurisdiction to negotiate with Native people and any relinquishing of authority to the provinces will weaken their position in the settlement of other issues. There is also the concern that, if the province assumes the responsibility of providing health care to status Indians, the funds originally identified for Native health would simply be transferred to general revenue without a method of accountability.

A number of *submissions to the commission describe federal and provincial disputes over Native health care as causing inequality in service delivery and accessibility. In many instances, access to and quality of provincial services depends upon federal compensation levels, and the level of provincial service offered by the exchange-of-service arrangement is inferior to service provided by the Medical Services Branch.

Half of the province's Native population live off reserves, but services to meet this population's needs are only beginning to develop. Existing health care services should be encouraged to hire Native staff and to begin talking with the Native community. A resolution to the ongoing jurisdictional dispute between the federal and provincial governments regarding the delivery of health care to Native Canadians must be found.

Programs and Services: Health and Welfare Canada

• *Nursing and Community Health Programs*

Fifty federal nurses provide services through ten nursing stations, 19 health centres and 48 health stations – serving two-thirds of the 196 bands in the province. In southern BC, provincial community health nurses serve 62 reserves (approximately 9,000 Indians) under a *federal exchange-of-service arrangement which provides $1.25 per capita funding. Health centres are the administrative offices of the resident federal nurse and are usually situated in towns or cities close to a number of Native communities. The health centre nurses visit health stations on reserves to provide public health programs. Included in these community services are: health education; nutrition; dental services (not including the non-insured health benefits); medical and dental advice and assistance; environmental health services; and drug and alcohol abuse prevention and counselling.

The community health nurse program in BC is augmented by Native Community Health Representatives (CHRs), trained in health education, who work with the community health nurse in *health promotion and education. There are 165 CHRs in reserve communities, but they are not evenly distributed, with many of the smaller reserves not having any.

Health representative training is funded by the Medical Services Branch, and provided by the Native-run Salishan Institute in Chilliwack. Health representatives do 18 weeks of training with three additional weeks of training, each year, and some advanced courses are now being offered. The program is also reevaluated every five years, and the national Community Health Representative organization is currently conducting a national evaluation in selected communities and non–Native communities.

This program works well. It is from the community, culturally appropriate, and locally based and controlled. It is a model that could be easily adapted to urban Native communities.

The organization, structure and management of health services to Indian people is riddled with complex issues of jurisdiction, constitutional responsibility and legislative directives that do not reflect the health needs of Indian people.
NAT-020

Substance abuse programs, also offered on reserves, are sponsored by the National Native Alcohol and Drug Awareness Program (NNADAP). NNADAP supports 84 prevention projects and employs 103 workers in BC. It operates five treatment programs with a total of 74 beds. Another five treatment programs are being developed to provide 50 additional beds. The five operating facilities – Hazelton, Alert Bay, Tofino, Nanaimo and Vernon – treated 597 cases in the fiscal year 1988-89. NNADAP's BC budget for 1991/92 is $7.3 million.

If communities have a Community Health Representative Program or a National Native Alcohol and Drug Awareness Program, workers associated with these programs operate out of the health stations. Nursing stations, with a resident nurse, are always situated on reserves and provide primary clinical care and public health programs. Isolated communities without immediate access to a hospital or physician qualify for a nursing station.

Therefore, the commission recommends that:

11. the number of native community health representatives be increased to improve coverage on reserves and provide coverage to off-reserve communities.

12. governments provide enhanced health care training opportunities for Native people by

   a. helping Native people enter the various health care disciplines by designating seats and providing preferred entry status and educational and communal support;

   b. providing health training in rural communities; and

   c. providing programs to help Native students meet entrance standards.

• *Medical and Hospital Insurance Plan*

In every province, with the exception of BC and Alberta, the cost of Native health services is covered by general provincial revenue, which includes federal transfer payments. In BC and Alberta, however, a portion of medicare costs are covered by premiums which the federal government pays for status Indians. In BC, the federal and provincial governments annually negotiate this sum, currently set at $7 million a year.

• *Non-Insured Health Benefits*

Medical Services Branch offers a number of benefits to status Indians, on and off reserves, which are not covered by the province's MSP. These include:

- patient transportation
- basic dental care
- pharmaceutical and medical supplies
- optometric supplies

• *Mental Health*

The Medical Services Branch lacks a formal mandate or dedicated resources for mental health programming. However, psychologists are available, and funds are available to train workers about family violence. Two hundred and seventeen thousand dollars – $2.78 for each of the 78,000 on-reserve Indians – has been set aside for BC.

The need for Native mental health programs is evident in high Native suicide rates. Recent disclosures regarding abuse in residential schools, the high degree of substance abuse, an increasing number of Native people contracting AIDS, and the incidence of family violence all warrant direct and effective action.

Therefore, the commission recommends that:

13. the provincial government work with Native communities and federal authorities to develop community-based mental health programs, such as sexual abuse counselling for the victim, the offender and the family.

• *Other Programs*

The federal Medical Services Branch offers training and development of clinical personnel, and career and employment programs such as the Indian and Inuit Health Careers Program, the School of Dental Therapy, and the Research and Development Program for NNADAP.

The Health Careers Program is intended to encourage Native people to enter into the health care professions and funding is provided annually to hire four BC Native university students for jobs in health care. In addition, the NNADAP Research and Development Program funds $400,000 worth of national substance abuse research programs.

• *Health Program Transfer*

The federal government has announced that it intends to transfer MSB health programs (except non-insured benefits) to either band or tribal control and management. This transfer requires Native health authorities to develop compatible and comparable program standards. For example, if a band applied for transfer of programs, and was previously receiving the services of a half-time community nurse, then the financial equivalent to that position is what would be transferred.

Before a band or tribal council can enter into a health transfer program, it must undergo a pre-transfer planning phase, funded according to population size and depending on the band's health care program and financial expertise. If the services are minimal, or the band does not have sufficient experience in financial or group administration, a transfer would not be feasible. Once the pre-transfer phase is completed, transfer negotiations begin.

A number of concerns have been raised about the level of funding for these Native–operated health care services. There is a need to close the current gaps in health care, to guarantee future funding and to resolve such issues as liability insurance. Even with a complete transfer of services gaps will exist.

- Services that are currently provided by MSB to reserve communities – the basis for funding – are often inadequate. Many of the smaller communities do not have Community Health Representatives or alcohol and drug workers, and community health nurses are often unable to spend sufficient time in the community.
- Many of the small, isolated communities not only lack community-based programs, but health services outside the community are not easily accessible.
- Neither level of government has dedicated funds to support physician services and mental health services in Native communities.

Many of us
turn our anger inward
until we explode,
hurting
those closest to us.
Hurt upon hurt
festers until
everything around us
becomes painful,
and that's where
the pattern
of abuse thrives.
NAT-025

The problem with the transfer arrangement is that whenever the federal government gives something up they don't give the resources to go along with it.
NAT-024

There are 12 pre-transfer projects, involving 86 bands, underway in BC. Two transfer agreements – between the Nuu-Chah-Nulth Tribal Council and the Nisga'a Valley Health Board and both levels of government – have been signed. But even with support from both levels of government, the Nisga'a have experienced a lack of adequate funding. In their submission to the commission, they pointed out that they need increased funding for physician services, nursing, emergency services, environmental health and mental health services. A particular area of concern is their inability to recruit and retain a physician. The provincial government should be prepared for an increase in the demand on provincial services by Native communities as limitations become apparent in the transfer program.

Therefore, the commission recommends that:

14. **where there are transfer agreements between the federal Medical Services Branch and Native communities, the provincial Ministry of Health negotiate agreements to fund physician services and mental health services.**
15. **where there are no transfer agreements between the federal Medical Services Branch and Native Communities, the governments ensure that full health services are available to all Native communities.**

Social Services

The federal Department of Indian and Northern Affairs (DINA), the provincial Ministry of Social Services and Housing, and the Ministry of Labour and Consumer Services' Alcohol and Drug Programs offer a variety of social services to the BC Native population. DINA's programs, limited to reserve residents, support social service activities such as child welfare, adult care and family support services. Larger bands have their own social service staff, and child welfare, which is usually under the jurisdiction of the province, is now directly delivered by the Nuu-Chah-Nulth Tribal Council, the Carrier Sekani Tribal Council, the Spallumcheen Band and the McLeod Lake Band as a result of agreements reached with both levels of government.

The Ministry of Social Services and Housing has also established a Native Services Unit in Vancouver, and has funded various Native initiatives with different Native non-profit organizations. In Vancouver, such programs include a transition house, a group home, a street kids program and a teen mothers program. They also support a liaison worker. A contract has also been entered into between the government and the Urban Representative Body of Native Nations Society (URBAN), a group consisting of Native service organizations in the city.

The province also contributes funds to alcohol and drug programs, including the Round Lake and Kakawis treatment centres, and alcohol and drug counsellors in 20 of the province's 21 Native friendship centres.

HIV and AIDS

The prevalence of substance abuse and sexually transmitted diseases among the Native population indicates that AIDS is a serious threat to the Native community. Although provincial and federal AIDS statistics for the Native community are low, anecdotal evidence indicates that approximately 100 cases of AIDS and HIV infection exist in Vancouver's Native community alone. AIDS and HIV cases exist in other Native communities in the province, some in isolated areas. Unless major emphasis is placed on AIDS education, this disease could seriously threaten Native people in the next few years.

Educational initiatives by both levels of government have been sporadic and inadequate. MSB currently spends $1.00 per person to educate reserve communities about AIDS.

Therefore, the commission recommends that:

16. the reduction of sexually transmitted diseases among the Native population be a principal health objective for governments, without regard to jurisdictional disputes.

17. the new Native Health Branch work with Native communities to
- **a. establish AIDS educational and preventive programs;**
- **b. develop culturally appropriate educational materials; and**
- **c. establish a Native AIDS centre to support education and prevention programs, distribute information and operate an AIDS 1-800 line.**

> *The time has come and gone*
> *when it was possible to afford the luxury*
> *of talking about our problems.*
> *Action and the commitment*
> *of appropriate levels of resources*
> *to ensure solutions to the problems*
> *that exist are the present requirements.*
> NAT-021

IMMIGRATION AND MULTICULTURAL HEALTH

Between 1975 and 1990, 1,908,415 people immigrated to Canada. Of this number, 279,031 people (14.6%) took up residence in BC, the majority of these in the Lower Mainland. Between 1990 and 1995, a further 1,170,000 are expected to arrive in Canada and indications are that approximately 160,000 will settle in this province. Twenty-two percent of British Columbians are now foreign born, compared with a national average of 15 percent. Unless fertility rates or migration trends change noticeably in BC, that number will increase.

New Canadians are a culturally diverse group speaking over 50 different languages. In 1988, approximately 59 percent of the *Family Class of immigrants, 86 percent of the *Refugee and Designated Classes, and 35 percent of the *Independent Immigrant Class had no knowledge of English or French. In the same year, 46.9 percent of the students enrolled by the Vancouver School Board spoke English as a second language. Children make up a growing proportion of Family Class immigrants.

The health and health care needs and expectations of these people are as diverse as their backgrounds. Many of them are as unfamiliar with the type of health care provided in Canada as they are with the languages spoken by the people who provide it. Many are not immunized, or are in need of basic nutritional information, and many, such as victims of torture arriving here from roughly a dozen different countries, are in need of specialized treatment and care. Immigrants should receive the same standard of care as Canadian–born people.

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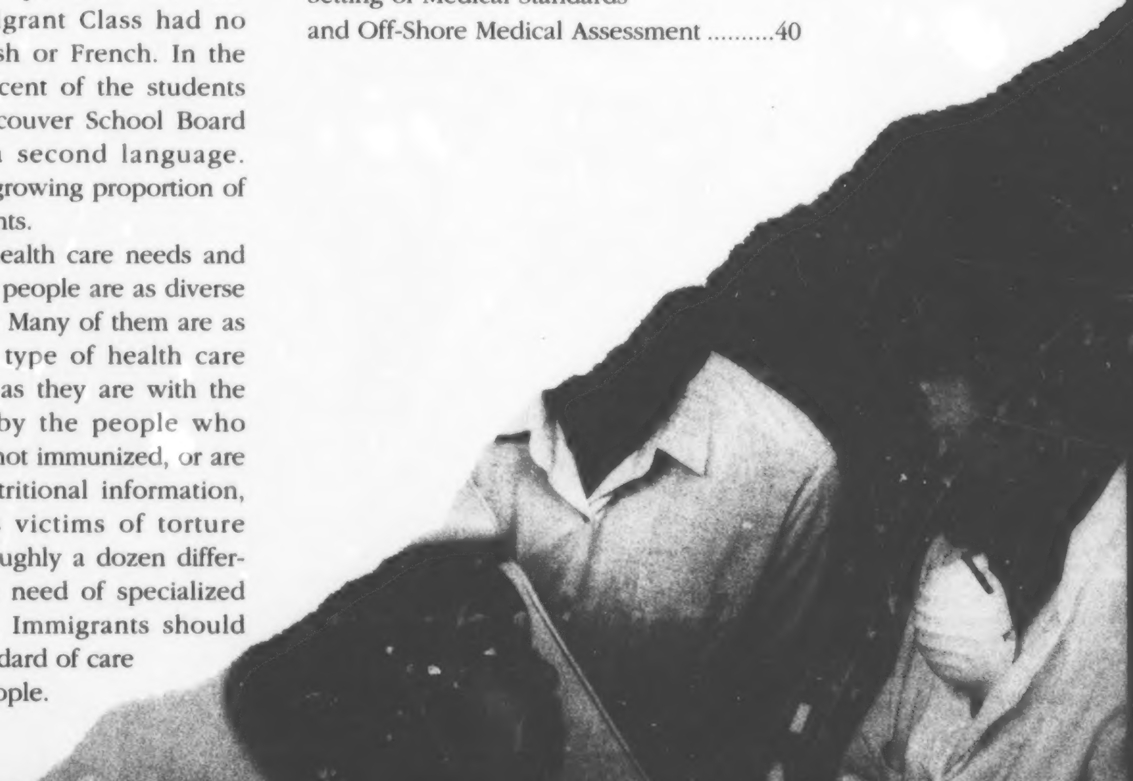


We have seen people who have died of breast cancer or uterine cancer because their access to the health care system was compromised by linguistic and cultural isolation.
SOC-075

Cultural Diversity and Medicare

A commitment to *universal* health care demands that attention be paid to cultural and linguistic factors. However, surveys conducted in Britain, the United States of America and Canada suggest that many people of minority ethnic background are not using existing services because those services are not culturally responsive or *accessible* to them.

Problems which these surveys have identified include:

- the inability of clients to speak with health care workers
- unrealistic expectations by health care workers for individual participation in care plans
- health care workers' lack of knowledge of, and sensitivity to, other cultural norms and taboos.

Finding out about available health care services can be a problem. Many immigrants are not used to the kinds of services provided here, and it is hard for them to learn about them through their traditional networks of communication. Once they have access to a particular service, their comfort level is usually low because of the way they are treated. There are often problems due to a lack of sensitivity to cultural differences on the part of care givers and a lack of skills for delivering health services across cultural boundaries, particularly when there is a language barrier. Among some immigrant populations, there is a poor understanding of body functions and other health concepts which Canadian-born individuals accept as general knowledge. In many cultures, women are not allowed to initiate access to health services. As a result, some women do not receive the health care that they need, and community and prevention programs sometimes miss identifying high-risk individuals.

Delivering *comprehensive* health care services to immigrant peoples is difficult. Their needs are minority needs, quite different from those of the dominant culture.

- Refugees have a need for mental health support due to post-traumatic stress and other conditions which have resulted from torture and persecution.
- Vancouver's *Healthiest Babies Possible* program has established that Vietnamese and Punjabi women are more likely to have low birth weight babies than the rest of the population. This may be due to dietary practices and a lack of appropriate medical care.
- Many immigrants have not received even basic immunizations against childhood diseases.
- There is a disproportionate number of hepatitis B carriers among people arriving from certain countries.
- Many immigrants suffer from intestinal conditions seldom experienced by Canadian-born people.

Dealing equitably with these needs requires non-traditional strategies. In Vancouver, non-professional community health aides from different cultural or linguistic communities have provided invaluable outreach services to people from ethnic minorities. They do this by informing immigrants about the services available, by helping people who need assistance in gaining access to these services, and by acting as interpreters. They supply information to service providers about the needs and expectations of immigrants, and help the providers decide the best way to deliver services.

Community health aides also help health care workers understand the different cultural patterns of health behaviour and health care behaviour, thereby making services more effective and patient cooperation more probable. Illiteracy in English is a major barrier, and the availability of printed health information in various languages is limited. The aides also assist in the development of material in other languages, and in identifying which media will reach different communities.

Cultural Diversity and Professionals

Ethnic and cultural diversity can overwhelm professionals. College and university curricula contain very little practical information on the effect of culture and ethnicity on the delivery of equitable health care. Health care workers have very few opportunities to learn how to deliver health care to ethnic minorities more effectively.

Language barriers are the primary concern for health care workers dealing with immigrants. It takes additional time to see a patient whose English language skills are not well developed, and finding and using interpreters can be frustrating. This problem is further complicated by the increase in outpatient services, with their heavy reliance on patient education. Neither block funding nor the *fee-for-service schedule take into consideration the extra time needed to overcome language barriers. This creates a reluctance among health care workers to deal with immigrant people. Language barriers also deepen the complex problems associated with *informed consent.

Racism is also an issue. There are growing staff-to-staff and staff-to-client problems, as the workforce and society become increasingly racially mixed. Some people – immigrants and Canadian-born – refuse treatment or care because of the racial or cultural background of the care provider.

Cultural Diversity and Quality of Care

Traditionally, ethnic families care for their elderly; ethnic seniors usually live within an extended family which includes a mix of generations. But the pressure of Canadian society often results in families having to place elderly relatives in care facilities, causing extreme guilt and, occasionally, family breakdown.

Once placed in a care facility, ethnic seniors lose the network of support they enjoyed in their own home and community. This is a common experience for all seniors, but is exacerbated for those immigrants who have not had the opportunity to socialize with people from different backgrounds and who have difficulty in relating to people whose life experiences are so different from their own. Many are unable to communicate with other residents and staff, have difficulty with non-traditional food, and are alienated by the memory exercises used by caregivers.

One of the issues discussed in ***Long Term Care*** is the present policy of assigning people on waitlists to the first available facility. This puts undue stress on care givers and receivers and further complicates decisions faced by ethnic families. It may even discourage ethnic groups from developing such successful nursing homes as the Finnish-Canadian Rest Home, the Villa Cathay Care Home, the Icelandic Care Home, and the Louis Brier Home.

*Cultural Diversity and *Health Promotion*

The promotion of health and healthy lifestyles among new Canadians is difficult to achieve, due in part to:

- a lack of general knowledge and skills
- a lack of effective community programs (e.g., hepatitis B immunizations)
- excessive use of institutionally based interventions
- social and economic conditions.

The Multicultural Policy of the Province of British Columbia, announced in October, 1990, commits the government of BC to:

- encourage the removal of societal, structural and institutional barriers to full participation in society
- ensure that all British Columbians have equal access to programs and services
- sensitize institutions to the multicultural reality of society, so that services are delivered more effectively and equitably
- ensure that all British Columbians are treated equally and equitably, irrespective of racial, ethnic, cultural or religious origin.

> *I recognize that there is no single way of delivering health services to a city or province enriched by different cultures and different communities.*
> MUN-020

The Ministry of the Provincial Secretary is also responsible for a Cabinet Committee on Multiculturalism. However, this committee does not have a member representing the Ministry of Health. That ministry itself has recently struck a Multicultural Health Committee.

Programs and services under a multicultural policy should operate in co-operation with existing programs and services. The structure should remain sufficiently flexible to accommodate changes in the mix of ethnic and cultural groups which constitute the community. Public and community health departments will have a considerable role in implementing a multicultural health program. They should be key participants – along with community groups such as the Multilingual Orientation Services Association for Immigrant Communities (MOSAIC), which is developing a "Training for Trainers" program – in planning a long-range strategy which includes access to appropriate health care services, general *prenatal education, information on infant care and practices, nutrition education for cultures with vegetarian diets, and immunization and prevention of early childhood diseases. Natives on reserves have the assistance of community health representatives. They take people to the doctor or the hospital, translate and explain, and generally help people in dealings with the health care system. In addition, they are the local promoters of good health. We think that model could usefully be employed in other communities.

Therefore, the commission recommends that:

1. **the development of *Continuing Care services and facilities for specific cultural and linguistic communities be encouraged.**
2. **the Ministry of Health**
   a. **create non-professional community health aide positions;**
   b. **implement MOSAIC's "Training for Trainers" program;**
   c. **develop health education information for distribution through ethnic newspapers and magazines, multicultural television and radio channels, and home videos; and**
   d. **develop training and orientation programs for health care workers to make them better able to deal with immigrants.**
3. **a representative from the Ministry of Health sit on the Cabinet Committee on Multiculturalism.**

Federal/Provincial Issues with Respect to Immigration and Health

The federal government is responsible for establishing the objectives and principles of immigration for Canada. It has jurisdiction over the selection of immigrants and the level of immigration, and sets the admission criteria for immigrants.

Since 1978, legislation has required that the federal government consult with the provinces before deciding on the numbers, classes and medical admissibility of immigrants to Canada. There has also been a federal shift from short-term to long-term planning, and to more comprehensive consultations. The Ministry of the Provincial Secretary is involved in these consultations, but it has only an advisory role. It does not have any way of enforcing its preferences or recommendations.

Some provinces, such as Quebec, have a formal agreement with the federal government which permits them to determine the numbers and types of immigrants who will be accepted by that province. Quebec also shares in the selection of immigrants and has more responsibility for settlement programs.

BC does not have such an agreement, but it is in the process of negotiating one and already shares the responsibility for administering *The Immigrant Investor and Entrepreneur Programs*.

The negotiations between Employment and Immigration Canada and the provincial government have focused on:

- planning, which includes responding to labour trends; decisions concerning medical admissibility; and the development of appropriate support services
- the *offshore selection process
- the settlement of immigrants.

The intent of the negotiations is to:

- make these processes more effective
- make the province's recommendations more influential
- increase the province's involvement with selection
- establish a clearer and more functional agreement on the roles and responsibilities for settlement programs and language training.

While the province has no constitutional responsibility for immigrants, under the Constitution Act, 1867, the responsibility for health care rests with the provincial government. The provision of services for landed immigrants is made through the provincial Medical Services Plan (MSP). This means immigrants, once accepted, are treated the same as Canadian-born people and are entitled to universal, accessible, comprehensive and portable health care. In BC, immigrants are entitled to coverage after the completion of the month in which they arrive plus two more months.

In 1990, BC received 1,350 government sponsored refugees. The medical needs of government sponsored refugees are covered immediately upon arrival, through the Federal Adjustment Assistance Program. This coverage is good for a period of one year or until a job has been procured, at which time the individual pays into MSP.

The federal government funds a receiving agency, the Immigrant Services Society of BC, to assist with the initial settlement of these government sponsored refugees. Mental health, support and adaptation assistance are available through the Immigrant Services Society. Government sponsored refugees are often not eligible for other settlement programs, such as those to assist in job search, cultural sensitization or parenting, because they do not fit the criteria set by funders of these programs.

Setting of Medical Standards and Off-Shore Medical Assessment

The federal government is responsible for policies on medical inadmissibility, which deal with the exclusion and removal of would-be immigrants who are considered medically undesirable.

We really don't have good control on who has been and who has not been immunized, and that's compounded by the influx of people coming to BC.
HUT-035

The federal government's responsibilities include:

- setting standards
- making decisions about diseases for which screening should be required
- the consequence of testing positive for any of those diseases.

The three main reasons for questioning a person's admissibility under these provisions are that:

- the person poses a real or perceived threat to the Canadian population
- the person requires health care services not available in Canada, or the use of which would put a Canadian-born person's ability to get that service in jeopardy
- the burden of cost placed on the health system is ruled to be too high.

These policies have a direct effect on health care and social service costs to the province. The Ministry of Health has a Medical Advisory Committee which reviews applications for immigration when there is some uncertainty about medical admissibility. The province, however, only plays an advisory role in determining whether an applicant for immigration who does not clearly meet the health criteria should be allowed to enter Canada.

The issue of medical inadmissibility is currently under review by the federal government. BC has submitted a formal statement concerning:

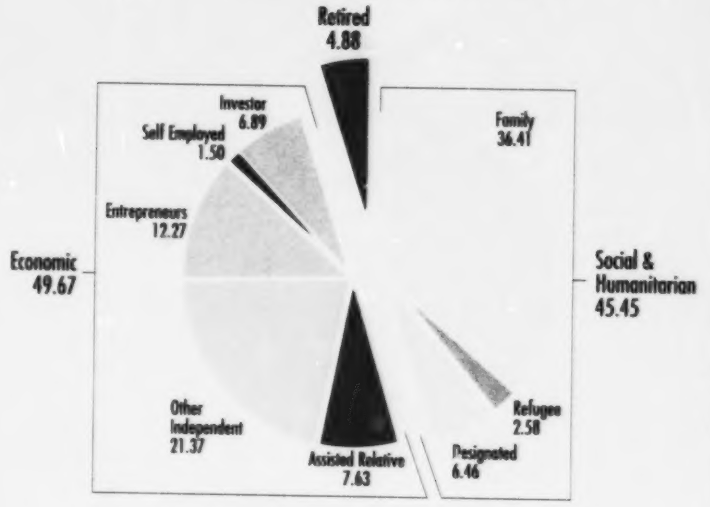
- medical testing/screening procedures
- the assessment of demands on the health system
- the role and responsibility of the province in decisions on medical inadmissibility.

The provincial government has also requested a commitment from the federal government to provide current provincial information to federal off shore agencies. The province also wants its recommendations to be accepted by federal agencies. And, in the cases where Minister's Permit overrides the provincial Medical Advisory Committee's recommendation, the province wants the federal government to be responsible for the health and social service costs of those individuals covered by the permit.

Therefore, the commission recommends that:

4. **the provincial government urge the federal government to:**
   - **a. assume all medical and social costs for refugees and immigrants for a five year period after their entry into Canada;**
   - **b. immediately implement mandatory standard immunization, prior to entry to Canada;**
   - **c. require all individuals seeking *landed immigrant status to present evidence that they have received a complete series of immunizations;**
   - **d. refuse entry as an immigrant to any person who tests positive to an infectious disease that is incurable, such as HIV or hepatitis B; and**
   - **e. require any person who plans to leave Canada to obtain appropriate immunizations before leaving and, if demanded, present evidence of immunization upon return.**

TOTAL IMMIGRANT LANDINGS BY CLASS



Source: BC Ministry of Finance and Corporate Relations, 1990

SERVICES TO PEOPLE WITH DISABILITIES

Disability is somewhat
of an equal opportunity situation.
At any given time in our life
any one of us could join
this elite group.
Round Table Discussion

People with disabilities and their families are faced with variations in the range, quality and organization of support services in BC. When variations exist, those who benefit from improvements in one area are often frustrated by barriers in another.

The system's shortcomings create hardships and limit the disabled person's ability to live independently. The challenge we face in integrating people with disabilities into society is to coordinate the management of our existing resources in a way which reduces the consequences of disabilities.

This chapter is concerned with:

- the lack of information about the distribution and needs of people with disabilities
- the discrepancies in services across the province
- the funding of services and programs
- the access to services
- the vocational and employment opportunities for people with disabilities
- the recruitment, training and retraining of caregivers
- the loss of power to make decisions
- the disincentives to employment

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Most of those who benefit from the policies and services discussed here are people with disabilities due to spinal cord and head injuries, neuromuscular diseases, or mental handicaps. But there are other people with disabilities whose needs are as acute. The problems discussed here weigh upon the lives of many other British Columbians with chronic disabling conditions that cannot be cured. When these people need access to the health care system, special efforts may be needed for them to have the same benefits that other people enjoy.

For instance, we have been told that:

- extra time should be allowed for health care workers to understand and help the mentally handicapped
- the deaf may need translators
- the blind need instructions in Braille or on tape.

Some disabling conditions are preventable and early intervention is important. Therefore, whenever feasible and appropriate, prevention (discussed in ***Public Policies for Health)*** should receive the highest priority.

LEVELS OF INTERVENTION

Condition	prevention	rehabilitation	maintenance
specific onset	x	x	s
normal aging			x
congenital defect	x	s	x

x = primary intervention objective
s = secondary intervention objective

Disabling Conditions

Some disabilities, such as head and spinal injuries, are associated with a specific event and onset, and prevention and rehabilitation interventions are feasible. With rehabilitation it is possible to maximize the level of cure or correction that can be achieved and to reduce dependence. After the highest level of correction has been achieved, maintenance of the disabled person's ability to control the immediate environment becomes a priority. Neuromuscular disorders call for different interventions.

Spinal cord and head injuries are caused by trauma – falls, sports injuries and motor vehicle accidents – which, in most cases, can be prevented. Programs aimed at preventing these injuries are being delivered by the Insurance Corporation of BC (ICBC), Workers' Compensation Board (WCB) and the Canadian Paraplegic Association, BC Branch. The major target groups for these programs are young children and adolescents.

Muscular dystrophy and amyotrophic lateral sclerosis (Lou Gehrig's disease) are only two of 40 neuromuscular disorders causing progressive muscle weakness and wasting. Polio, which has had such a devastating history world-wide, appears to disable some survivors many years after the disease has passed.

Multiple sclerosis and Parkinson's disease are chronic, progressive diseases of the nervous system involving the brain and spinal cord. The cause of these disorders is not known.

Spina bifida is a congenital neural tube defect involving the spinal vertebrae and sometimes the spinal cord. Although the cause of spina bifida is unknown, the defect can now be detected through *prenatal screening. Parents should be informed about the consequences of spina bifida and similar congenital defects and be given the opportunity to terminate the pregnancy.

Cerebral palsy is a group of non-progressive disorders resulting from the malfunction of the motor centres and pathways to the brain. Low birth weight and sub-normal levels of oxygen in the blood of perinatal infants have been identified as possible causes of cerebral palsy. Although there is some disagreement as to what extent birthweight is correlated with this disorder, efforts to reduce the incidence of low birthweight could reduce the incidence of cerebral palsy as well as other developmental problems.

Some mental disabilities are due to congenital or genetic defects, such as Down's Syndrome, or to brain injuries, usually resulting from a blow to the head. These disabilities are often stable; the degree of impairment will remain relatively constant throughout the person's life. Other mental disabilities are the result of neurological diseases, such as Alzheimer's disease, which lead to a gradual and irreversible deterioration of mental abilities over a number of years.

Access to Services Across the Province

People with disabilities have difficulty getting services outside of Vancouver or Victoria. Travel costs are often prohibitive, and some people and their families are forced to permanently leave their home communities in order to receive the services they need simply to function.

In 1989, hospitals outside of Vancouver were surveyed for the paediatric services they offered. Only 15 had one or more outpatient clinics for children with special needs and few had rehabilitation services, social workers, psychologists, or respiratory technologists with special training in caring for children with disabilities. According to the survey, consultative services, clinics and diagnostic services are all limited in regional and small community hospitals and outpatient physiotherapy clinics tend to focus on the treatment of acute episodes rather than on the maintenance of the chronically disabled.

Access to services would be easier for all people with disabilities if, in the future, policies and programs were based on accurate knowledge of the location of the disabled in the province, the nature of their disabilities, and the availability of resources. A strategic plan based on this information would:

- include standards of care and outcome indicators for each group of disabilities
- include priorities for funding and developing programs directed at those disabling conditions which have the greatest probability of improvement
- identify and support programs which increase the level of independence of people with disabilities, in turn reducing the demand for dependent care and improving the contribution to society.

The commission is aware that there are already several registries for the handicapped, including the Health Surveillance Registry. But the need exists for a comprehensive resource registry for people with mental and physical disabilities and for one body that is accountable and responsible for maintaining it. Access to this registry, specifically identifying those resources available to the disabled, should be available through the Ministry of Health's toll free line (1-800-742-1820). The ministry should publish this number and its hours of operation regularly.

More children are surviving increasingly severe handicaps and becoming adolescents and adults. They require support, periodic consultation and ongoing services. At present these services are scattered or non-existent.
HCP-112

Therefore, the commission recommends that:

1. **program development be directed toward**
    a. **those conditions for which there is the greatest probability of cure; and**
    b. **improving functional capacity where there is little or no possibility for remediation.**
2. **the Ministry of Health**
    a. **develop, maintain and publish a *Resource Registry* in conjunction with the Ministry of Advanced Education, Training and Technology and the BC Housing Management Commission. The information available on the resource registry shall include**
        i. **a list of services and instructions on how to receive them;**
        ii. **the type of equipment available and its location in the province;**
        iii. **the names and telephone numbers for all of the agencies providing services and equipment to people with disabilities; and**
        iv. **information on the location and nature of available accommodation, including information on shared accommodations and shared hours of home support ;**
    b. **develop and maintain a *Registry of Individuals with Disabilities* through the Vital Statistics Division and the Child and Youth Secretariat, to assist in the development of long range plans and to monitor the changing needs of the population;**
    c. **organize assessment and treatment services for the disabled at the regional level; and**
    d. **use Children's Hospital, Queen Alexandra Hospital, Sunny Hill Hospital and G.F. Strong as provincial agencies jointly responsible for setting standards and providing consultation to the regions.**

Children with Disabilities

• *Eligibility Criteria*

The *At Home Program* currently serves approximately 900 children with severe disabilities who would otherwise be institutionalized. However, consumers and service providers told the commission that the criteria for entering the *At Home Program* need to be expanded to include children with less severe disabilities.

A child who can complete one or more of the four daily living activities – bathing, eating, dressing, or moving – does not qualify for the program. For example, a child with cerebral palsy who needs a wheelchair for mobility but can feed himself does not qualify for the *At Home Program*. The families of these excluded children must pay for all of the equipment and medical supplies to care for their children at home. Often the child must be institutionalized because the family is unable to cope.

Therefore, the commission recommends that:

3. the eligibility criteria for the *At Home Program* be re-evaluated and the results made public. The principal objective of the program, to maintain children at home, must be kept.

• *Funding*

No one knows what levels of funding and resources are currently assigned to children with different levels and types of disabilities. Therefore, no one knows if the available resources are being used efficiently or effectively. For example, when integrating children with disabilities into schools, the initial funding for the *In School Support for Special Needs Students (In School Protocol)* was directed toward Level III children because their safety needs were the most critical. As a result, Level II children have special care assistants but these assistants are not supervised nor do they have written care plans to follow. This particular problem will be rectified in the 1991/92 school year.

Disabilities which can be cured or corrected should have the highest priority for resources. However, inadequate program structures and a shortage of therapists may make the correction of disabilities such as speech/language defects unlikely for many children.

Therefore, the commission recommends that:

4. the *In School Protocol* be evaluated to determine the costs and benefits of the program to people with various levels of disability, and to ensure that priorities for resources are assigned to the levels of disability most amenable to correction.

We were also told that whether or not someone is suffering from a mental or physical disability, the Medical Services Plan (MSP) will only pay for 12 physiotherapy visits each year. While such a policy is easy to administer, we believe that it results in serious service problems for a number of people. In contrast, people can get speech and language services and occupational therapy through programs which do not place a limit on the number of visits. In the chapter ***Health Care Personnel,*** we have recommended that the annual unit of 12 treatments by a physiotherapist be increased at the direction of the client's physician.

• *Recruitment and Training of Caregivers*

*Submissions from the *In School, At Home* and *Nursing Respite Programs* all report that they have difficulty recruiting and training caregivers. Certification of special care assistants also varies across the province and there is a shortage of licensed practical nurses and registered nurses who are trained to care for technology dependent children. The *Nursing Respite Program* has also reported that it cannot always fill requests for respite hours and that families must carry on without relief.

Therefore, the commission recommends that:

5. **community colleges develop certificate programs and extension programs that**
   - a. **train appropriate numbers of special care assistants; and**
   - b. **upgrade licenced practical nurses' and registered nurses' skills in caring for technology-dependent children and their families.**

• *Decision-Making and Inter-Ministerial Communication*

The commission was told that the issue of who has control over decision making for the child is magnified when the child receives services from a variety of agencies and programs. Children may receive services in school from the *In School Protocol* and receive equipment and medical benefits from the *At Home Program* and their families may receive respite from the *Nursing Respite Program.* In these multi-agency cases, gaps in communication, overlap of services and confusion over who is directing the progress of the child can occur. Problems with inter-ministerial communication further compound the difficulties parents have gaining access to the system.

Some families and program representatives are also concerned that LPNs and RNs overstep their roles in the home and attempt to direct the care of the child. The development of annual care plans, in conjunction with the family, would help reduce these conflicts.

The provincial Ombudsman has instructed the Child and Youth Secretariat of the Ministry of Health to report on the integration of planning, policy and program and service delivery, and on the creation of accessible services. Both the health care and social service delivery systems should be structured to allow individuals and families to choose their own lifestyles and health care.

Therefore, the commission recommends that:

6. **a multidisciplinary team develop a plan for each person with a disability and review the plan annually.**

• *Access to Services*

The Ministry of Health has confirmed that the quality and access to services for people with disabilities needs improvement. The Ombudsman Public Report #22, *Public Services to Children, Youth and Their Families in British Columbia: The Need for Integration* suggests that the provincial government must avoid the pitfalls of expedience whereby a child's needs are divided into service components to fit a fragmented system. This can lead to children with disabilities being denied services for no other reason than where they live or how old they are. An example is the transitional periods between preschool and school age, and school age and 19, which result in changes in services and service providers and which are often traumatic for the disabled child.

Case management is a system designed to support people with disabilities and their families in making decisions and in directing them to appropriate resources. To be effective, the case manager must have a broad knowledge of the support services and the health care system. The case manager's role is assumed now by consumer groups and service providers without financial backing. The usefulness of case management is currently being assessed by The Child and Youth Secretariat.

Adults with Disabilities

• *Criteria for Income Assistance*

Guaranteed Available Income for Need (GAIN) for the Handicapped provides an income of $694 each month plus medical and dental benefits and the option to purchase a yearly bus pass for $38. As of March 1989, 16,444 individuals were on the program.

To apply for *GAIN for the Handicapped*, a physician must state that a person's disabling condition precludes work. The situation is the same in other provincial rehabilitation programs, including the *Vocational Rehabilitation Services* funded by the Ministry of Advanced Education, Training and Technology. However, assessment of a person's employability would be more accurate if it were carried out by people working in the vocational rehabilitation field in consultation with a physician, rather than by a physician alone.

The vocational rehabilitation community views employability as a transitional state dependent on many things, including social and economic factors beyond the individual's control. Access to the income provided by *GAIN for the Handicapped* should not depend on what may be a temporary state of employability or unemployability.

Any person should be considered employable as a general standard, and employability should be regularly assessed. The professionals responsible for the assessment should define the conditions which may limit or help the person to work and a trial period of employment, with temporary access to GAIN, should be allowed. Consumer agencies are, for the most part, very successful in placing disabled persons in employment.

It is unjustified to have to label a disabled person permanently unemployable early in their rehabilitation in order for that person to receive income support.

The Ministry of Social Services and Housing (MSSH) offers vocational and job search programs to people receiving income assistance. The federal government funds the *Vocational Rehabilitation of Disabled Persons Agreement* and it is administered by the Ministry of Education, Training and Technology. This is a cost-sharing agreement with the provincial government for vocational rehabilitative services, sheltered workshops, home industries, job search, outreach programs and appeals. Some of the provisions of this agreement have not yet been implemented. These include an appeal process, outreach and appropriate follow-up.

Many a day
my wife and I
have come home
from trying to
get assistance
for our son
and cried ourselves
to sleep,
or ended up
unable to sleep
due to worry.
We have gone into debt
several times
trying to keep up
with the extra bills
for therapy.
We pay them off,
then he has a fall
and requires
additional help,
and the bills pile up
again.
IND-380

Therefore, the commission recommends that:

7. **the Ministry of Advanced Education, Training and Technology implement all parts of the *Vocational Rehabilitation for Disabled Persons Agreement.***
8. **people in the vocational rehabilitation field, in consultation with a physician,**
   - **a. determine the employability of people with disabilities; and**
   - **b. review that decision each year for the first two years.**

> *It would be*
> *more cost effective*
> *for us*
> *to institutionalize*
> *my husband.*
> *That would solve*
> *all the monetary*
> *and physical problems*
> *we encounter daily.*
> *We choose*
> *to have him at home*
> *for as long as possible*
> *despite these hardships,*
> *but it is*
> *certainly not through*
> *the encouragement*
> *of the*
> *health care system*
> *of BC.*
> *IND-318*

• *Income Assistance Programs as Disincentives to Employment*

The province's current income assistance programs can create disincentives for people with disabilities who want to work. The lack of paid medical benefits in lower paying jobs, coupled with an income requiring self-payment of premiums, becomes a disincentive to seeking employment.

Therefore, the commission recommends that:

9. **the Ministry of Social Services and Housing create employment incentives by**
   - **a. providing *GAIN for the Handicapped* during a person's period of rehabilitation and retraining for employment; and**
   - **b. establishing a trial period during which employment income is subsidized by GAIN and medical benefits are paid by GAIN.**

Medical Supplies and Equipment

In 1987, the Services to the Handicapped Branch of the Ministry of Health conducted a review of medical equipment and supplies. *The Report on the Provision of Medical Equipment and Supplies to the Chronically Ill and Disabled Population in BC* identified seven problem areas.

- Inequities in the benefits available. People with disabilities covered by WCB, ICBC or other extended medical benefits, or who can afford to pay for equipment are well served. But former MSSH clients, now in *intermediate care facilities, who require mobility and environmental aids and people with disabilities without extended benefits are not.
- Lack of coordination of the many agencies providing equipment.
- Lack of information about access to equipment and suppliers.
- Organizations and departments providing equipment have erected barriers to access as a way of coping with demands that exceed their resources. Common barriers are means testing, slow decision making, and the need for the client to exhaust other sources first.
- Varying assessment skills and product knowledge of health care workers.
- A lack of rehabilitation therapists in rural areas.
- The centralization of specialist health services and medical suppliers.

An example of the barriers that can exist for people with disabilities trying to get medical equipment is the experience of a resident of a *long term care facility whose medical expenses are paid for by the MSSH. This ministry does not pay for wheelchairs and walkers because the responsibility for intermediate and *extended care facilities lies with the

Ministry of Health. At the same time, the Ministry of Health states that, in these facilities, equipment that is for the sole use of a resident is the financial responsibility of that resident. In many cases, the resident cannot afford to purchase the equipment and therefore goes without, severely restricting independence.

The commission is aware that the Assistant Deputy Minister's Steering Committee (ADMSC) on Disability Issues is developing a new policy on providing technical aids. This should include providing and maintaining equipment, recycling equipment, maintaining an inventory of equipment which is available throughout the province, creating public awareness about available services, providing a central contact for the public, and coordinating all local agencies who provide equipment. The committee is advised to heed the following recommendations.

Therefore, the commission recommends that:

10. the Ministry of Health immediately release *The Report on the Provision of Medical Equipment and Supplies to the Chronically Ill and Disabled Population in BC* to the public.

11. the government of BC improve access to medical supplies and equipment by

- **a. developing a standard policy for the provision of supplies and equipment which will apply to and define the responsibilities of the Ministry of Health, the Ministry of Labour, the Ministry of Social Services and Housing, the Ministry of Advanced Education, Training, and Technology, the Workers Compensation Board, and the Insurance Corporation of British Columbia;**
- **b. consolidating responsibility for the provision of medical services and equipment in one unit in the Ministry of Health;**
- **c. contracting with community agencies in each area to provide and maintain equipment;**
- **d. providing mobility aids for personal use in long term care facilities;**
- **e. informing the public of equipment and supply benefits and government policy; and**
- **f. eliminating the present requirement of the Ministry of Social Services and Housing that individuals must first seek out and use all other sources of funding for equipment and supplies to meet the criteria for assistance.**

A number of submissions to the commission mentioned the difficulty some people have in getting hearing aids. Some submissions claimed that the hearing aids sold by the government are not affordable and recommended a subsidy program. Others argued that there were difficulties obtaining equipment for children outside of educational settings. Prolonged delays in receiving approval, equipment or testing were common complaints attributed to the government's procedures.

The provincial Hearing Services Branch provides assessment, identification and rehabilitation services, and sells and distributes hearing aids. The Branch contracts out for hearing aids, selects a range of styles and options to suit the caseload, and provides hearing aids from an approved list of suppliers on a one-to-one basis according to the hearing needs of clients. Hearing aids are provided for all people on social assistance and access to the program is by referral from an ear/nose/throat specialist, a general practitioner, a *public health nurse or through an audiology clinic.

Currently, 70 percent of the program resources are devoted to children. A high risk registry for infants has been in operation in BC for over ten years, and it was recently expanded in scope. Hearing screening for children is also provided in schools. However, screening is not provided in long term care facilities and staff are not educated to recognize and manage hearing impairments among residents.

Few people appear to be aware of the program provided by the Hearing Services Branch. Regardless, the limited resources of the *Hearing Program* make it difficult for the branch and *health units to respond to the current demand for hearing services. It is possible that a centrally run program is no longer a realistic option.

The commission was unable to deal with this subject in greater detail. It should be carefully reviewed and the cost of the program should be evaluated in relation to improving hearing capabilities among different target groups. Alternative ways to manage the program should be considered to reduce delays, and improve coverage and responsiveness of the program.

Housing

Population projections suggest that the number of wheelchair-accessible housing units needed in BC will increase in the future. The policy of de-institutionalization, and the estimated 44 new cases of spinal cord injury and 300 - 400 new cases of head injury in BC each year are also escalating the demand. Yet, of the 199 rent-subsidized units built in BC in 1988, only 21 were for people with disabilities. An additional 197 units of nonprofit special needs housing were built for the disabled who require on-site care. Obviously, people with disabilities are spending a large portion of their limited income on housing.

Therefore, the commission recommends that:

12. the BC Housing Management Commission
  a. ensure that its registry of people with disabilities requiring modified housing is linked to the registry of individuals with a disability; and
  b. re-examine cost comparisons for building wheelchair-accessible units or wheelchair-adaptable units and converting them at a later date, and publish the results.

13. all housing built with public funds be designed such that it can easily be made wheelchair-accessible.

Transportation

People from the Lower Mainland with disabilities are often restricted to outings planned well in advance by Handy Dart's requirement to pre-book rides. Private taxis are available, but the cost is prohibitive. Accessible transportation is usually unavailable outside the Lower Mainland, and there are no provincial standards for privately run taxis or custom transit.

A provincial transportation committee has been formed to address transportation needs on a province-wide basis. Its report should be released to the public upon completion. A major transportation objective should be to provide services which will keep people living in their own homes.

Home Support Workers

The major issues in home support are the provision of a sufficient number of hours of care to ensure client independence, and the retention of home support staff.

The 1990 report, *It's All About Caring: Employment and Education in the British Columbia Home Support/Homemaker Industry*, examined the human resource needs of the home support industry and found that the primary reasons for homemaker job dissatisfaction were:

- low wages
- poor working conditions
- irregular hours
- limited benefits.

Wages alone play a large part in homemakers' leaving a home support agency to work in a long term care facility once they have received training and experience. Homemakers working for unionized agencies receive $8.50 per hour at the entry level and $10.50 per hour if they have taken the home support course offered by some community colleges. Non-unionized agencies pay $8.75 per hour or less. Unionized aides working in long term care facilities receive a starting wage of $12.53 per hour. Although some incentives to improve job satisfaction (training, orientation, better scheduling and establishing levels of homemakers to encourage career progression) now exist, homemakers' wages still fall below those of other workers requiring comparable training and experience.

In March 1989, the BC Association of Community Care (formerly the Home Support Association of BC and the BC Long Term Care Association) reported that 56 percent of home support workers leave their jobs each year. This rate has now dropped to roughly 50 percent, possibly due to an industry wage increase in April 1990 and the recent recession.

Accessible, affordable transportation and subsidized housing are two key areas that can profoundly affect a disabled person's ability to live independently. IND-380

Home Support

The number of hours of home support service allowed to people with disabilities according to fixed categories established by the Long Term Care Division does not always meet the client's needs. More flexible hours of service, including a system to handle emergencies and respite, would ensure that the client could be maintained at home. This might prevent caregiver burnout and make it possible for the disabled person or the home caregiver to maintain employment.

A consumer-controlled brokerage system is one option presented in submissions to the commission for hiring and retaining home support staff. In this system, the number of home support hours are decided by the Long Term Care Division but the client is responsible for hiring staff, thereby reducing agency costs which are then passed on to the home support staff in wages. Higher wages usually guarantee that a better trained employee can be hired and that there is a lower turnover of staff. This system is used in Vernon by the North Okanagan Handicapped Association and by a number of people in Vancouver.

The Vancouver Health Department's *Enhanced Consumer Participation Model* is currently being evaluated. This model allows the client to hire home support staff from a home support agency. The model ensures that *continuing care policies and procedures involving the safety of the client and homemakers are maintained, and provides accountability for government funds. The client's number of hours of care is decided by a long term care assessor. In addition, the home support agency maintains responsibility for supervising its employees.

A small number of disabled people hire their home support staff independently of an agency and do their own training and supervision. These individuals can be very flexible in the scheduling of staff. Wages paid are within the budget stipulated by the Ministry of Health and total number of hours provided is determined by the Long Term Care Division. Consumers using this system report a low turnover of trained staff.

Each such consumer-controlled system results in greater autonomy for the disabled person. However, not all people with disabilities have the management skills to assume these responsibilities. A need is thus created for case managers who can assess the skill level of potential participants in these systems and perhaps counsel the participants as they take on more responsibility for directing their own care.

Therefore, the commission recommends that:

14. the Ministry of Health, in conjunction with consumers and service providers, evaluate the criteria for establishing care levels to ensure that the current hours of home support provided in the community are sufficient for independent living and flexible enough to accommodate the disabled person's education and employment.

Specific Concerns of Those with Mental Disabilities

Many of the problems which affect those with physical disabilities also affect those with mental disabilities. However, some issues are specific to those with mental disabilities.

The commission was told of a tendency among the public and some health care workers to confuse mental disabilities with mental illness. This is unfair and harmful and can lead to inappropriate treatment and institutionalization.

New legislation is needed to protect people with mental disabilities. This legislation should address guardianship – which is of particular concern to adults with mental handicaps who have no legal guardian – and *informed consent.

Another concern is the quality of care which people with mental disabilities receive. Some people claim that it is poor and criticize health care workers for their inability to work effectively with the mentally handicapped. While de-institutionalization of people with mental disabilities was widely endorsed, concern was expressed about the lack of community support, especially group homes and daily assistance.

Other issues include:

- a lack of treatment centres and long term care facilities for people with severe mental disabilities.
- a lack of information about different diseases and appropriate caregiving
- a lack of programs designed for patients with neurological disorders living in geriatric facilities
- cutbacks in physiotherapy and other *home care services
- limited physician knowledge of neurological diseases.

Catastrophic Injuries and Compensation Systems

During the hearings, the commission received a number of submissions about compensation for those who suffer catastrophic head, spinal and other injuries. We were told that the present system has inadequacies and does not protect everyone equally.

Injuries resulting from motor vehicle or occupational accidents involve the Insurance Corporation of British Columbia or the Workers' Compensation Board. In some circumstances, rehabilitation therapy is made available with some security that the individual will receive care in the future. In other cases, a sum of money is awarded as a result of a settlement or judgement. Sometimes the amount is insufficient due to divided liability; sometimes a settlement intended to last a lifetime is spent within a few years. Other people with disabilities do not receive any assistance and have only basic care that does not extend to maintaining a severely injured person in a home environment. We were also told of cases where the individual has received sizable awards for future care but retains those funds and relies on the community to provide care.

The commission did not receive sufficient information to determine what steps ought to be taken to alter the system under which compensation for future care is now awarded. Enough was heard to indicate that this is a serious issue which deserves study.

Therefore, the commission recommends that:

15. there be an independent enquiry into the problems related to catastrophic injuries, including:

- **a. quality of care;**
- **b. cost of care;**
- **c. methods of compensation; and**
- **d. the relevance of fault.**

* GLOSSARY

SUBSTANCE ABUSE

In British Columbia:

- 24 of every 100,000 women die of lung cancer every year and the rates will increase in the future
- 30 percent of all cancer deaths are attributable to smoking
- 30 percent of domestic homicides involve alcohol
- 45 percent of all drownings and 70 percent of accidental poisonings are alcohol-related
- 60 - 80 percent of all spinal cord injuries are substance-abuse-related.

If you see somebody stoned from alcohol,
I'll bet you that half the people will laugh at him,
reeling down the street.
If you knew that he was stoned because of cocaine,
or heroin,
or something, you would gasp and say,
"How awful!"
They're both stoned.
But... alcohol is accepted.
Society uses it...
If we could cut down on the legal drugs,
we'd do a great deal - liver,
heart, disease, cancer,
a whole lot of other things would be improved.
MUN-025

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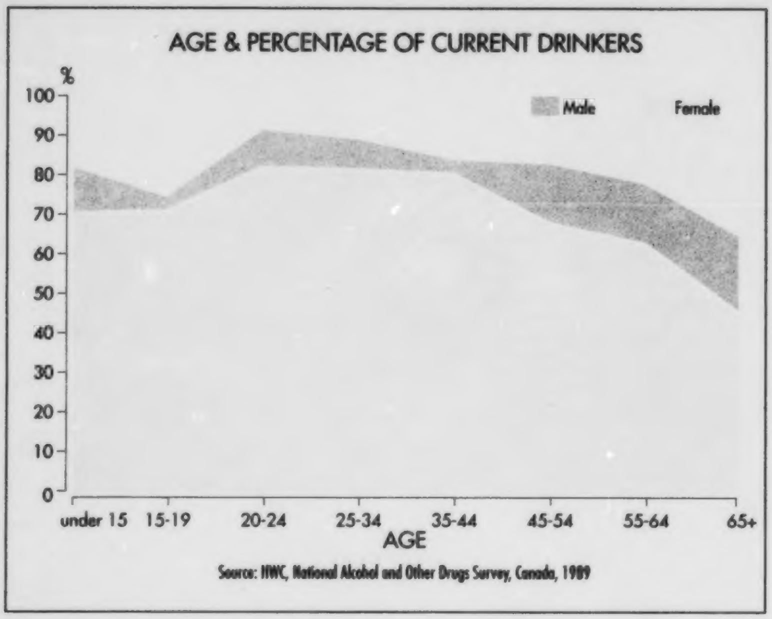
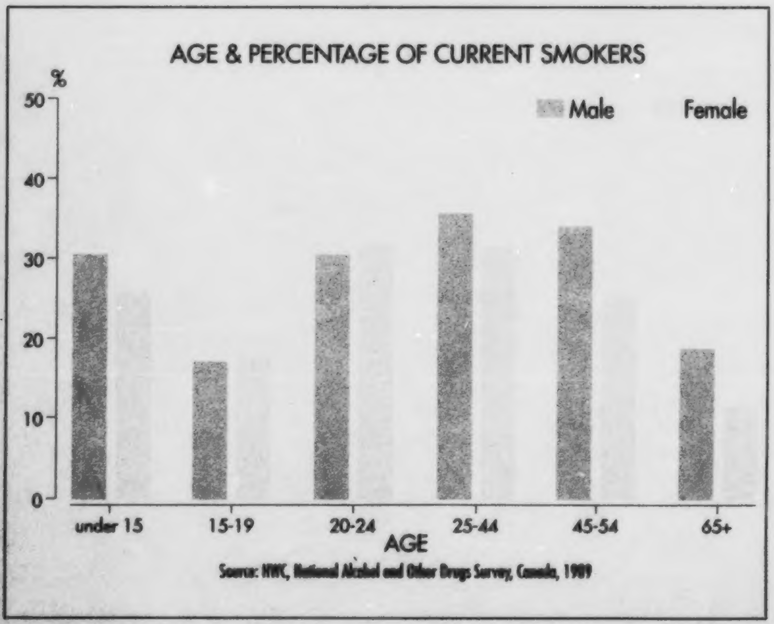


AGE & PERCENTAGE OF CURRENT DRINKERS

Source: HWC, National Alcohol and Other Drugs Survey, Canada, 1989

The Challenge

Alcohol consumption and the use of licit and illicit drugs are declining in Canada, according to the June 1990 National Alcohol and Other Drugs Survey. However, in our society, the use of alcohol and drugs has become the norm and a large number of Canadians continue to drink heavily and to misuse drugs. As collecting information on the cost of substance abuse in BC has not been a priority for the government, the available data are limited and confusing. Estimates of the financial consequences of substance abuse range from $2 billion to $5 billion a year.



AGE & PERCENTAGE OF CURRENT SMOKERS

Source: HWC, National Alcohol and Other Drugs Survey, Canada, 1989

Surveys by Alcohol and Drug Programs (ADP) show that, consistent with national trends, alcohol and drug use is declining among BC youth. But substance abuse has almost become a right of passage for the young and positive news of declining use is tempered by results that show our youth experimenting with alcohol and other drugs at increasingly earlier ages. For example, the ADP survey showed that the rate of alcohol use by Grade 12 students in BC is greater than the rates of adult use in a number of other provinces. Over 20 percent of children aged 12-15 smoke cigarettes regularly.

The inappropriate use of medications can cause illness, hospitalization, or even death. Yet approximately 40 percent of British Columbians over 60 years of age use non-prescription drugs every day, a trend which generally increases with age. Our seniors, who make up 12 percent of the BC population, currently consume 40 percent of the prescription drugs. Alcohol misuse among the elderly, which is difficult to recognize, could be as high as 10-15 percent.

Substance abuse is also a major challenge facing Canada's Native peoples.

> *The Nak'azdli reserve has 1,058*
> *registered members on April 1, 1990,*
> *six hundred of whom suffer from the effects*
> *of alcoholism in one form or another.*
> NAT-017

The involvement of Natives in designing and developing alcohol treatment programs has been successful, and is fundamental to the future of Native programs.

Therefore, the commission recommends that:

1. **the priority for prevention, planning, program development and services must be, in order of importance,**
   - **a. children and youth for tobacco and alcohol;**
   - **b. Natives for alcohol and drugs; and**
   - **c. seniors for prescription drugs and alcohol.**
2. **Native peoples should be involved in the design and development of any future Native drug and alcohol treatment and prevention programs.**

The sale of alcohol and drugs benefits people living on either side of the law. The Royal Canadian Mounted Police estimates that the retail value of illicit drugs sold in the Canadian market in 1985 was over $10 billion. Cannabis products accounted for approximately $5.6 billion in sales, heroin for $2.8 billion and cocaine use for sales in excess of $1.2 billion. At the same time, the BC Treasury alone received over $420 million from the sale of alcohol and more than $315 million from the sale of tobacco in 1990.

Alcohol abuse is a major problem in BC and we believe that public monies should not be spent on alcohol. Government involvement symbolizes the increased tolerance of a dangerous substance which has a damaging effect on thousands of people, every day of their lives.

Therefore, the commission recommends that:

3. **no public monies be used to purchase alcoholic beverages.**

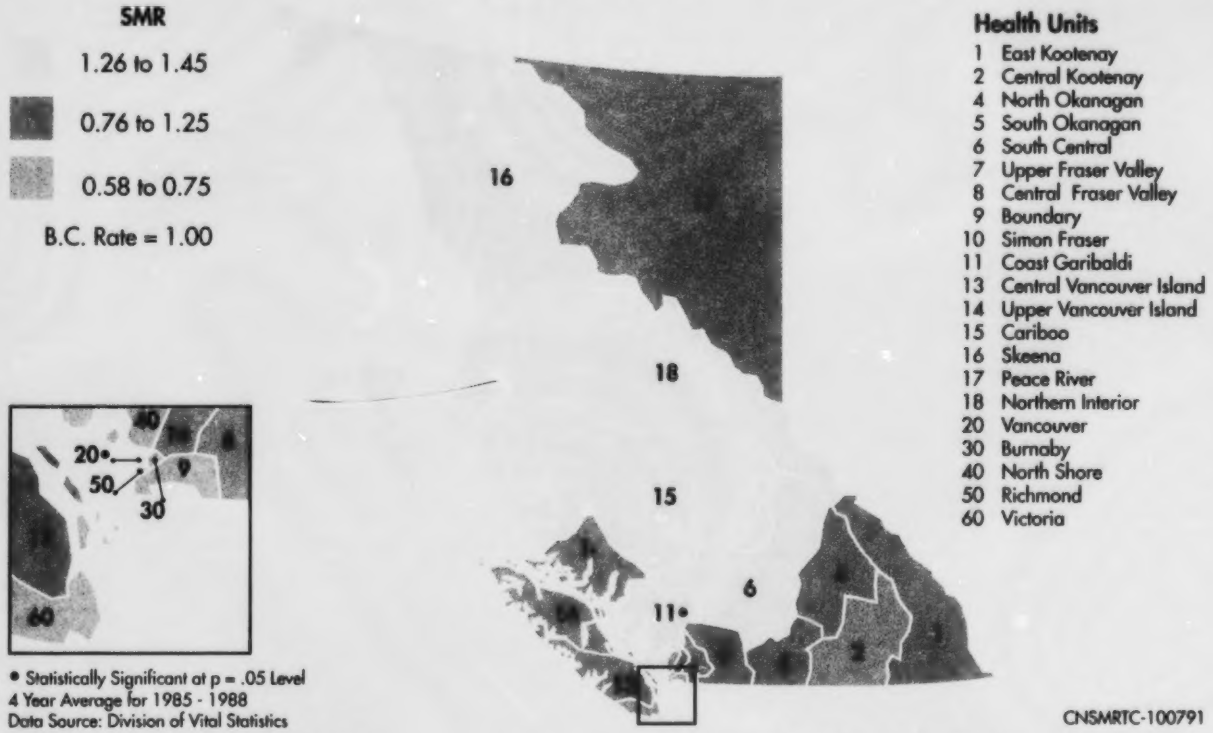
We also believe that the practice of permitting expense accounts to include alcoholic beverages should be ended.

The Present System of Care

Prior to 1973, alcohol abuse services in BC were provided by the Alcoholism Foundation of BC. Other drug services, mainly concerned with opiate dependents, were delivered by the Narcotic Addiction Foundation of BC. This division of focus and the resulting duplication of services and competition for scarce resources was frustrating to users, providers and politicians alike, and in April of 1973 the Alcohol and Drug Commission Act was passed to establish one system of care for substance abuse in BC.

The Alcohol and Drug Commission, which was responsible for the controversial Heroin Treatment Program, was disbanded in 1982. A board of government officials was then established to integrate the newly formed Alcohol and Drug Programs' services into existing ministries.

The ADP structure included two main components: a central operation run from Victoria, and five regional units: Lower Mainland; Fraser Valley; Thompson-Okanagan/Kootenays; North; and Vancouver Island, Gulf Islands and Central Coast. ADP conducts research through contracts with independent investigators and a Research Review Committee awards funds to projects "addressing the causes and treatment of substance abuse".



BC STANDARDIZED MORTALITY - ALCOHOL RELATED CAUSES BY HEALTH UNIT

SMR
1.26 to 1.45
0.76 to 1.25
0.58 to 0.75
B.C. Rate = 1.00
Health Units
1 East Kootenay
2 Central Kootenay
4 North Okanagan
5 South Okanagan
6 South Central
7 Upper Fraser Valley
8 Central Fraser Valley
9 Boundary
10 Simon Fraser
11 Coast Garibaldi
13 Central Vancouver Island
14 Upper Vancouver Island
15 Cariboo
16 Skeena
17 Peace River
18 Northern Interior
20 Vancouver
30 Burnaby
40 North Shore
50 Richmond
60 Victoria
16
18
15
6
11•
20•
50
30
9
40
60

• Statistically Significant at p = .05 Level
4 Year Average for 1985 - 1988
Data Source: Division of Vital Statistics

Prepared by: Health Economics & Planning Branch, Ministry of Health

CNSMRTC-100791

Map Source: Planning & Statistics Division, Ministry of Finance & Corporate Relations

Between 1981 and 1988, ADP was located in the Ministry of Health. Then three separate initiatives combined to create several major changes in the substance abuse treatment system.

- The 1987 Jansen Report, *Liquor Policies for British Columbians,* documented the extent of public concern about the abuse of alcohol in the province. It urged the government to introduce mandatory alcohol education programs in schools, and suggested that funding be tripled to approximately $65 – $70 million per year. It also recommended against privatization of liquor sales.
- The 1987 Ryan Report, *Task Force on Alcohol and Drug Abuse in the Work Place*, called for major changes in ADP as a way to prevent worksite substance abuse. It also supported an increase in the annual budget of ADP to $65.5 million.
- The Kaiser Substance Abuse Foundation and the Vancouver Foundation started a number of community initiatives.

In 1988, the government moved the ADP to the Ministry of Labour and Consumer Services and announced the Community Awareness and Action Program which "supplements $26 million a year currently spent on substance abuse programs, more than doubling these resources over the next three years." The Program has added $68 million over three years to the existing budget of ADP, but these funds have not been included in the base budget. This means that ***programs funded under the Community Awareness and Action Program must meet service needs without the security of stable budgets, causing unnecessary problems within the system of care***.

Since the creation of ADP, treatment and prevention services have been expanded through the addition of contract agencies and the corresponding reduction of direct government services. The result is that approximately 90 percent of services in BC are delivered through contracts with autonomous societies.

The New System of Care

Briefs to the royal commission suggested two major themes:

- the government should be commended for its efforts since 1987
- the present system of care is not designed for a comprehensive attack on substance abuse.

The concerns most often expressed to us were:

- the location of ADP within the Ministry of Labour and Consumer Services
- the lack of a clear legislative mandate for ADP
- the lack of clear goals and a comprehensive plan to guide program development and service delivery
- perceived adversarial relationships among ADP, its agencies and private contractors
- staff reductions
- the difficulties agencies experience with short-term contracts.

After listening to these concerns, the commission has concluded that what is needed are leadership and direction, not more programs. We also think that contract agencies should be used, but that there should be stability of funding.

> *It can be appreciated that the treatment system has known little stability. It has grown in a reactionary fashion without long-term planning. The system is peculiarly vulnerable to political pressures and most treatment facilities have arisen as a result of local agitation for funding. Moreover, individual approaches and philosophies were encouraged as there was no cohesive approach to the treatment of addictive disorders. Several attempts have been made to set program standards but because of constant change within the system it is only in the past year that the first stages have been completed.*
>
> D. Graham Report on Physician
> Funding Delivered to Alcohol Drug Programs

• *Location*

Other provinces have experimented with the focus, structure and location of a substance abuse agency. Two approaches predominate. One is to integrate alcohol and drug programs and services within various existing government ministries. The other is to establish a strong, autonomous organization linked to government, generally through a health ministry.

Integration was tried in the early 1970s in Quebec. In response to the generally well-received Castonguay Report, Quebec integrated a sizable and respected substance abuse agency into a number of ministries. When the province tried to reestablish an autonomous agency in the mid 1980s, it was impossible to identify the alcohol and drug resources which, by that time, had been blended into various ministry budgets.

Autonomy is more common. For example, the Alberta Alcohol and Drug Abuse Commission, the Addiction Research Foundation of Ontario, the Alcoholism Foundation of Manitoba, and the Nova Scotia Commission on Drug Dependency are autonomous agencies. All of them:

- are linked to government through Order-In-Council appointments to a board and interact with the Ministry of Health
- have direct communication between the chairperson of the board and the minister
- have a chief executive officer who confers with the deputy minister of health and the assistant deputy ministers
- are mandated by government through an Act of the Legislature
- have objects of incorporation that are broad in design and include prevention, treatment, research, health education, training and development.

Therefore, the commission recommends that:

4. the province establish the BC Alcohol and Drug Commission (ADC) that

   a. consists of a Board of Commissioners, appointed by Order-in-Council and charged with governance of the ADC;

   b. has objects of incorporation which are broad in design, including prevention, treatment and research;

   c. is clearly separate from the Liquor Distribution Branch, the Liquor Control and Licensing Branch of the Ministry of Labour and Consumer Services, and private industry;

   d. has a CEO at the level of a deputy minister; and

   e. has a chairperson who will liaise directly with the premier during the initial four years. If the ADC is linked to the Ministry of Health, the chairperson will communicate directly with the minister and the CEO will confer with, not report to, the deputy minister of health.

• *Planning before Action*

The purpose of ADC should be to encourage and assist British Columbians to achieve a life free from substance abuse. This purpose should be achieved through:

- a strategic plan with measurable outcomes
- a community–based strategy which promotes control and action through local groups. These community groups will assist the regional and provincial planning authorities to set policy.

Clarity of purpose and leadership require that the board of the ADC be given a period of time to develop a plan which includes:

- the reduction of supply and demand for alcohol, tobacco and other drugs
- treatment, prevention, research and evaluation
- policy and program development
- service delivery through direct or funded agencies
- urban and rural needs
- local and regional involvement in planning and allocating resources and in implementing programs

- acquiring and using personnel and financial resources
- lines of communication between central and regional authorities
- coordination of training and development activities at the central and regional levels.

• *Prevention*

There are four complementary preventive strategies that we suggest the ADC adopt:

- *Control*, whereby legislation which controls the availability of drugs and alcohol is proclaimed and enforced.
- *Influence*, which promotes initiatives designed to modify people's attitudes and behaviour.
- *Competency Development*, which teaches people skills to help them make responsible decisions regarding drug and alcohol use.
- *Environmental Design*, which attempts to create environments more conducive to healthy behaviour.

Therefore, the commission recommends that:

5. all four public health strategies (control, influence, competency development, environmental design) be considered in order to develop a balanced strategic plan.

6. at least one-third of the resources of the Alcohol and Drug Commission be devoted to prevention.

• *Treatment and Rehabilitation*

If intervention begins when an abuse problem is first identified, there is a greater likelihood that the intervention will be effective. This, in turn, can reduce the costly use of treatment facilities, but it requires that people remain in their communities and maintain their social support systems while getting help with their problems.

The cure
for many diseases
lies not in
our laboratories
but in our legislatures.
IND-282

In some areas of the province the demand for treatment is high and people have to wait for up to ten weeks to be admitted to a treatment program. In other areas there are vacant beds and outpatient slots. Early intervention is an important part of treatment, ***and the province's resources must be reallocated to address the pressure points and ensure early interventions***.

Therefore, the commission recommends that:

7. treatment services begin when an abuse problem is first identified.

8. priority be given to services which permit the client to live in the community while participating in treatment, and that assessment and diagnostic expertise be available throughout the province.

• *Research and Policy*

The Addiction Research Foundation of Ontario is recognized throughout the world as an expert on addiction research. It is also the only provincial addiction organization which has maintained a strong research function. ADC will not have the resources necessary to establish a similar structure. However, ADC will need reliable provincial alcohol and drug information on which to base programs and policies. It must establish a research capability and an information system designed in collaboration with the people who will use it. The results of ADC's research would affect the policy and program development functions of ADC and organizations such as the Liquor Distribution Branch and the Liquor Control and Licensing Branch of the Ministry of Labour and Consumer Services.

• *Evaluation*

The purpose and intent of evaluation programs must be to improve effectiveness and efficiency and to appropriately allocate resources. To date, the quality of most evaluations has been poor.

Therefore, the commission recommends that:

9. the outcomes of alcohol and drug treatment programs be evaluated, and the results of the evaluations be used to improve program planning and administration.

• *Training and Development*

In the early 1970s, the federal, provincial and territorial governments identified training in the field of substance abuse as a high priority. As a result, the Federal-Provincial Task Force on Training for Alcohol and Drug Services was formed.

The *Final Report of the Task Force on Training*, dated May, 1975, contained a blueprint for establishing the National Training System. This led to the development of instruction materials such as *Core Knowledge* and *Prevention in the Drug Field* which have been used extensively throughout Canada. This national initiative also led to the establishment or expansion of many training departments. The School for Addiction Studies, operated by the Addiction Research Foundation in Ontario, is one such example.

Therefore, the commission recommends that:

10. the Alcohol and Drug Commission develop training and development programs in the area of alcohol and drug abuse which will ensure the availability of personnel to meet the needs of the province.

• *Funded Agencies*

Funded agencies currently providing prevention and treatment services under contract to the BC Alcohol and Drug Program should be part of the planning process. They need to:

- participate in program and policy development
- be able to recruit and retain qualified personnel.

The ADC will need to:

- review existing contracts to determine their appropriateness and viability
- review the number and location of the existing funded agencies to determine whether it would be cost effective to amalgamate them
- perform financial audits to ensure that public monies are properly spent.

• *Central and Regional Communications*

While governments are often willing to establish advisory bodies, the moment these groups attempt to take over responsibility for programs, they cease to be seen as an asset. Their demise generally occurs shortly thereafter.

As a result, Canada lacks a local system which we could recommend to the ADC. Instead, British Columbians must take what they need from the experiences of other provinces and build an effective local system. The government and the province's communities must have a shared goal.

Alberta's Alcohol and Drug Abuse Commission's community development approach provides useful insights into the structure of a community plan. The three major components of Alberta's model are:

- moving program development and service delivery to the community
- field personnel participating in making decisions
- providing opportunities whereby the resources of funded agencies and private sector companies can be used to the benefit of the community.

The Nova Scotia Commission on Drug Dependency has also developed a community-based system which appears to work well in that province's rural areas. This system includes a network of local committees and regional boards connected to the commission. Both of these systems increase the relevance of substance abuse programs to the community. A modification of this process might be applicable to BC.

While the commission recognizes that the supply of illicit drugs is largely an international problem lying beyond the reach of local policies, it feels that law enforcement remains an important supply reduction strategy in BC.

Reducing Supply and Demand

Initiatives which focus on product availability, product price and patron age as ways to prevent substance abuse will be widely used in the future. Because of this, ADC's research should concentrate on the physical environment within alcohol outlets, on server training, and on the structure of the alcohol industry.

Therefore, the commission recommends that:

11. the Alcohol and Drug Commission support studies on the age of consumers, the availability and price of alcohol, the effect of the physical environment within alcohol outlets, the behaviour of servers and the structure of the alcohol industry.

• *Advertising*

The Canadian Radio-Television and Telecommunications Commission (CRTC) is currently considering proposals to permit the advertising of spirits in the broadcast media. If adopted, spirits would be advertised under the same rules which now apply to beer and wine.

According to industry, approximately $150 million is spent on alcohol advertising in Canada every year. The Brewer's Association of BC has said "...the brewing industry does not agree with those who call for a ban on the advertising of legally produced and sold beverage alcohol....there is no evidence that a ban on advertising would reduce alcohol sales or affect total consumption." This commission, however, is of a different opinion. We believe that alcohol advertising promotes unhealthy lifestyles and we are strongly opposed to its appearing in the broadcast media.

Therefore, the commission recommends that:

12. the provincial government
- **a. reduce the number of liquor outlets;**
- **b. reduce the hours of operation and days of sale of liquor outlets;**
- **c. stop liquor stores and commercial establishments from participating in the promotion of alcohol products;**
- **d. enforce rules which require that the license of any establishment found selling alcohol to minors or intoxicated patrons be suspended;**
- **e. ban all alcohol advertising;**
- **f. publish health warnings on liquor labels, with particular attention directed at the effects of alcohol on pregnancy;**
- **g. strictly enforce the sale of alcohol licences, including special occasion licences;**
- **h. index taxes on alcohol relative to the consumer price index; and**
- **i. respond to the CRTC proposal to permit the advertising of spirits in the broadcast media by indicating the ban on advertising of spirits should be maintained and extended to include beer and wine.**

Strategies to Improve Health

Alcohol and tobacco are directly and indirectly involved in the high cost of health care. Death and sickness caused by the use and abuse of these substances continue at a tragic rate. Tobacco products are directly related to lung cancer, emphysema and heart disease, while close to 500 British Columbians die in alcohol-related motor vehicle accidents (MVAs) every year. Both alcohol and tobacco are implicated in the rate of infant death and low birth weight babies.

• *Drinking and Driving*

A 1989 province-wide opinion poll showed that the public views drinking and driving as important as, or more important than, smoking, pornography, juvenile delinquency, racism, drug use, family violence, unemployment, or AIDS. The same survey recommended increased driver education, increased general public education, implementation of designated driver programs, increased police roadchecks, increased general enforcement, treatment for drinking drivers, free transportation for drinking drivers, increasing the driving age, and increasing the drinking age. ***Public Policies for Health*** discusses blood alcohol levels in further detail.

• *Types of Drinking Drivers*

Novice Drivers – Each year, about 40,000 new drivers are licensed in BC. Each year, about 20 percent of them are involved in an accident resulting in injury or death. Conservatively, a reduction of 10 percent in novice driver accidents would result in a net saving of $25 million each year.

Young men have the highest proportion of alcohol-related casualty accidents. They typify the inexperienced driver who consumes a relatively small amount of alcohol, does not believe that he is impaired, and has a single vehicle accident.

Substance Dependent Drivers (Alcoholics) – Males, 45 to 55 years of age, single, widowed or divorced, make up a high proportion of those charged with drinking and driving offences, but a relatively low proportion of those in alcohol-related traffic accidents – they have practiced drinking and driving for years. These groups are often repeat offenders and constitute up to 20 percent of the jailed population, representing a substantial cost to the justice system.

Dangerous Drivers – These drivers are neither naive nor alcoholic. They have a bad attitude regarding driving, a history of traffic violations that may or may not include impaired driving, and a history of traffic accidents that may or may not include those that are alcohol-related. They tend to be younger males, but are found in all age groups.

• *Counter Measures*

Different counter measures must be used in order to achieve the greatest effect in reducing alcohol-related traffic accidents.

Novice Driver Initiatives – New drivers have a high proportion of alcohol-related and non-alcohol related crashes at night. Restricting these drivers to daytime and evening driving may reduce accidents among this group by up to 14 percent. Graduated licensing, including curfews, *zero blood alcohol tolerance, passenger and speed restrictions, and improved training and testing, would also significantly reduce both alcohol-related and non-alcohol-related crashes among learners. Information on the effects of alcohol consumption and on the laws on drinking and driving should be included in driver training and testing.

Training, testing and graduated licensing will affect the novice driver more than the "dangerous" driver or the alcoholic. Nevertheless, novice drivers have the highest level of drinking-driving accidents and consequently should have countermeasures specifically designed to reduce their accident rate. The cost would be no more than the cost of passing legislation under the Motor Vehicle Act and revising the appropriate forms.

> *If the 1987 rate*
> *of alcohol-related accidents remains stable,*
> *about one in seven British Columbians*
> *will be killed or injured*
> *in a drinking driving accident.*
> W.G. Mercer -
> Counter Attack Traffic Research Papers.

*** GLOSSARY**

Impaired Driver Assessment, Referral and Treatment – Approximately 14,000 drinking drivers are charged each year in BC and a further 26,000 receive 24-hour driving prohibitions. There is, however, a 20-30 percent recidivism rate, and it appears that fines and incarceration are ineffective for almost a third of those who come into contact with the justice system for these offences.

Manitoba and Alberta already have successful programs for impaired drivers that combine problem assessment, referral and treatment. These programs exist outside the justice system and participation is on a voluntary basis. There is evidence that they do reduce repeat offences.

It is the responsibility of the Superintendent of Motor Vehicles to protect public safety by removing the driving privileges of people who pose a danger to themselves or to others. Under Section 25 of the Motor Vehicle Act, the superintendent can require a driver to "attend at a time and place to be examined as to his fitness and ability to drive and operate motor vehicles." Drivers charged with an alcohol-related driving offence could be assessed under this section whether or not they have a substance abuse problem that warrants the withdrawal of driving privileges.

The disease
of the decade
is trauma,
and an awful lot
of that is related
to alcohol;
drinking and driving.
HCP-064

It should be noted that a fee can be required for this assessment, without additional legislation. Failure to comply with the requirement for an assessment should result in loss of driving privileges.

With an assessment fee of perhaps $250 for each impaired driver, and federal reimbursement under the Vocational Rehabilitation of Disabled Persons Act, this program could be virtually self-sufficient. Any reduction in traffic accidents would, in effect, produce a profit.

However, the stage at which this countermeasure occurs will affect the success of the program. For example, drivers receiving assessment and perhaps counselling after their first alcohol-related driving offence will have a much better prognosis than those seen only after more than one conviction.

High Visibility Police Enforcement – Widely publicized drinking-driving roadchecks have proved effective in raising drivers' perceptions of the risk of apprehension. Currently, about one in three BC drivers is stopped every year during the Spring and Christmas CounterAttack campaigns.

Assuming that media time is donated, as it currently is through the BC Association of Broadcasters, a one week province–wide road check campaign uses 10,000 police hours, at a cost of about $500,000, plus $50,000 of promotional materials. Using these figures, a year-round high visibility campaign would cost $28.6 million, but could reduce drinking and driving accidents by at least 20 percent. The program would pay for itself.

As the Insurance Corporation of BC would be a major beneficiary of any reduction in accidents, it should bear program costs proportionate to its savings.

Therefore, the commission recommends that:

13. a countermeasure plan be introduced to reduce the proportion and severity of alcohol-related traffic accidents by 10 percent within three years. The plan shall include
   a. high visibility police enforcement; and
   b. impaired driver assessment, referral and treatment.

14. a system of graduated licensing be initiated for novice drivers, including:
   - **a. curfews;**
   - **b. zero blood alcohol tolerance;**
   - **c. passenger restrictions;**
   - **d. speed restrictions; and**
   - **e. improved training and testing.**

Tobacco

This commission supports the government's recent increase in taxes for tobacco products. Tobacco is a drug. The consequences of its use affect all of society, particularly through the cost of health care.

While not all lung cancer is attributable to smoking, a very high proportion is. As a general rule, tobacco is thought to be responsible for 30 percent of all cancer deaths.

From 1985-87 in BC, the average annual lung cancer death rate for men (45/100,000) was the third lowest in Canada (59/100,000). But women in BC had the highest rate (24/100,000). The lung cancer death rate overtook the rate for breast cancer in women in 1987. The increasing trend in lung cancer death rates for women will continue due to the fact that BC had the highest prevalence of smoking among women 20 years ago. Since then, smoking has decreased for both men and women but the decline has been greatest among men, down 43 percent, compared with a drop of only 19 percent for women.

The National Clearinghouse on Tobacco and Health collects information on a number of prevention programs and smoking cessation programs directed at teens. These programs could be offered through the regional programs of the ADC.

Therefore, the commission recommends that:

15. the provincial government
   - **a. license the sale of tobacco products and**
      - **i. revoke a licence if the licence holder sells tobacco to a minor; and**
      - **ii. suspend a license if there is a breach of any other regulation; and**
   - **b. not permit pharmacies to sell tobacco;**
   - **c. increase the legal age for buying and using tobacco products to age 19;**
   - **d. ban tobacco vending machines;**
   - **e. prohibit the sale of cigarettes in packets of less than 20;**
   - **f. require that wherever tobacco is sold, there be a sign prominently displayed that states, "Smoking tobacco is a major cause of death in BC and a major cause of injury to babies";**
   - **g. prohibit the use of tobacco by adults and children on all elementary and secondary school property;**
   - **h. require that the owner or operator of every establishment with an enclosed area that offers food or beverages to the public ensure that at least one half of that area is free of tobacco smoke and that all of the seats in that area are designated for non-smokers;**

Tobacco causes 30% of cancer deaths, 25% of heart disease deaths, 15% of stroke, 60% of chronic obstructive pulmonary disease, 10% of hospital days, 6% of physician visits, 8% of motor vehicle accidents - something that is not very well recognized - 40% of fire deaths, 100% of the deaths from second-hand smoke - which amount to only 38 per year in this Province or about that - 20% of low birth weight infants and, between 15 to 30% of all deaths of Canadians, depending on how you estimate it.
PRO-103

* GLOSSARY

i. ban smoking in all areas of any institution that receives any form of government funding except specified areas for geriatric patients and residents and persons receiving *palliative care; and

j. impose a tax on the promotion of tobacco products including the use of the name of a tobacco product in the promotion of any event, equal to 100 percent of the cost of that promotion. All of the tax revenue so collected shall be used for anti-smoking advertising campaigns to be run by a volunteer organization.

• *Tobacco Advertising*

We are aware that the federal legislation governing tobacco advertising has been struck down as being a matter for provincial governments and as being contrary to the Canadian Charter of Rights and Freedoms. The commission is of the view that banning tobacco advertising is very important. Many young British Columbians start smoking each year and will die from it. We think it is important that nothing be permitted that would encourage people to smoke.

Therefore, the commission recommends that:

16. a. the provincial government pass legislation similar to the Tobacco Products Control Act.; and

b. if the legislation is found to be contrary to the Canadian Charter of Rights and Freedoms, the province resort to Section 33(1) of the Charter to ensure that the prohibition against tobacco advertising is maintained.

MENTAL HEALTH

DONALD'S STORY

My son left a suicide note on his pillow
to tell us that he loved us very much
but that he was going to commit suicide
and he went out somewhere after 1:00 o'clock
in the morning and committed suicide
and it was 4 days before they found my son
and the reason was that it had begun to snow.
I never ever thought of him jumping...
Is there no way that we can...
set up a lost and found organization
for the human being who
cannot tell you that he's mentally ill...
They don't have to be schizophrenics.
They could have manic depression too
and be so unhappy they're out on the street
walking along with the bag ladies,
who are probably schizophrenic
many of them
and the old men shuffling down the alley.
That's what most of those people on the street are.
They're ill and nobody wants to look after them.

Transcript from Mental Health Day

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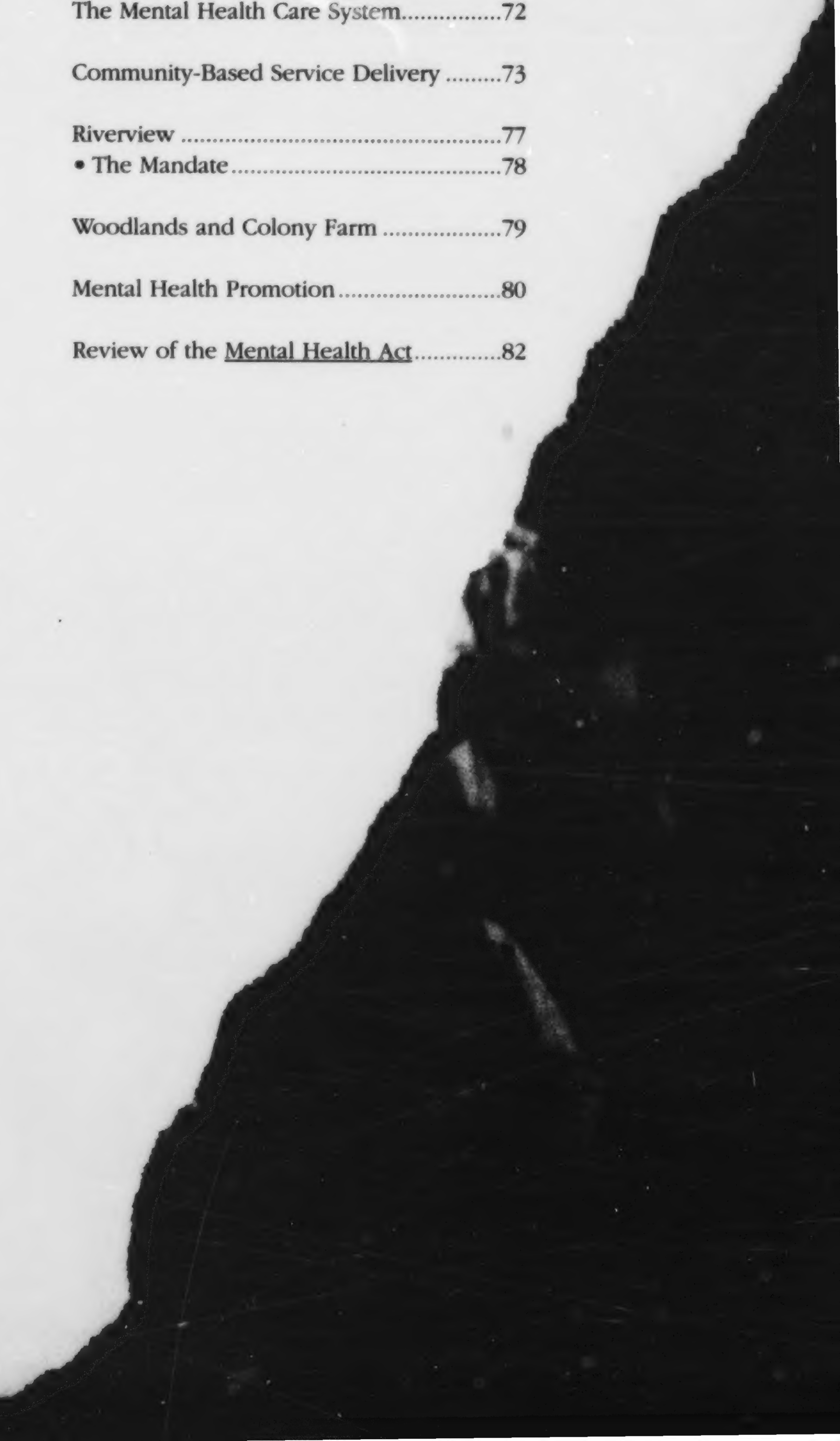

The Mental Health Care System

Although the subject is very complex, there is very little diversity in the opinions expressed to the commission about the problems with the mental health care system:

- the system has a medical and institutional focus
- the system relies on a small, relatively inaccessible group of medical specialists.

Nor was there diversity in the solutions proposed:

- recognizing that while some mental illness may not be preventable, countering the effects of poverty, poor housing, physical and sexual abuse, the lack of meaningful employment, and the abuse of drugs and alcohol is as important as medical treatment in the management and social integration of the mentally ill
- increasing the use of clinical psychologists.

The belief that mental health cannot be treated in a vacuum is now widely accepted and a continuum of services, from the promotion of mental health to *tertiary level care, is starting to develop within the province.

But to understand the present system of mental health care in BC, it is necessary to know that some of the basic structures of the previous system are still in place.

Prior to the 1960s, people with mental illness were incarcerated in large institutions, isolated from major urban centres, rather than treated in general hospitals. As a result of this physical separation from mainstream health care, services for the mentally ill were excluded from the federal/provincial cost sharing arrangements of the 1950s and 1960s, which are described in ***Protecting the Principles of Medicare.*** This meant that there was no financial incentive to rebuild the institutions as they deteriorated and few incentives for psychiatrists to locate near the institutions.

The advent of *psychotropic drugs in the 1960s made it possible to treat the chronically mentally ill on an outpatient basis and to shift treatment to the general hospital. But this shift was not part of a comprehensive policy and the mentally ill were generally moved into communities which were unable or unprepared to provide them with adequate support.

Recent efforts have been made to integrate some mental health programs into mainstream health care, and we recognize and support the Mental Health Services Division's efforts to develop a community-based service system. To take that step, though, the Ministry of Health must develop a coherent policy, and it must address the lack of the actual physical components necessary to ensure continuity and quality of care. Programs to follow up clients after their release from institutions must be an integral part of support services. Clients must be helped to contact community services, and treatment records must follow the clients.

Unfortunately, no large-scale model exists to guide the development of an integrated system. Reference is often made to projects such as the one in operation in Dane County, Wisconsin, but Dane County's programs are designed for a specific area and might not be transferable to this geographic and political setting.

In the past, the impetus for program and policy development in BC has come from the government, but it is now time for consumers to become more involved. Local advisory boards, made up of service providers, consumers and the general public, organized under an agency such as the BC branch of the Canadian Mental Health Association, are needed to provide policy and program advice.

Accountability for the system, as described in ***The Management of Health Care Services***, must be changed.

Therefore, the commission recommends that:

1. **the following guidelines be adopted to develop a coherent and managed system of care:**
   - **a. provide mental health services as close as possible to the individual's home;**
   - **b. avoid hospitalization whenever possible;**
   - **c. use the least restrictive setting and least intrusive intervention consistent with quality care;**
   - **d. provide continuity of care and active case management;**
   - **e. ensure that residential housing, day programs, and respite care receive priority;**
   - **f. involve the consumer in planning and implementing mental health services, and in accountability;**
   - **g. develop advisory boards at the local, regional and provincial level with broad representation;**
   - **h. develop provincial, regional and local multi-year plans for the promotion of mental health, and the prevention and treatment of mental illness;**
   - **i. give the highest priority to services for children and for youth; and**
   - **j. develop clear policy directives to the staff of all ministries to ensure coordination in policies, procedures and regulations.**

Community-Based Service Delivery

The people who submitted briefs to this commission generally agreed with the provincial policy to develop community-based mental health services. The reallocation of funds from institutions and administration to services in the community, described in the 1987 *Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital*, was considered to be an effective and ethical means of moving patients out of institutions while, at the same time, containing costs.

But the same people who supported the *Report* in their briefs do not feel that action has followed policy, and they described a mental health service that still lacks an overall plan. Funding has not been directed at specific policy objectives to achieve an integrated system.

The *Report* described what a community-based mental health system should provide:

- effective community treatment programs
- basic food, shelter and clothing needs
- mental health services that are fully integrated with education and social services.

> *Report after report supports the importance of home based services, but the funding has never matched the rhetoric.*
> *SOC-119*

The *Report* also outlined a number of fundamental principles and recommendations. If implemented, these would improve the management and quality of care provided in BC. The commission endorses these principles which include:

- supporting families and volunteer groups
- providing public education to increase understanding and acceptance of the mentally ill
- supporting consultation and liaison among the different service levels
- compensating general practitioners for consulting with mental health workers
- providing an appropriate range of services within each region
- providing special care therapeutic and rehabilitation programs
- providing outpatient treatment and case management through Regional Mental Health Centres
- providing special care units
- providing a range of services from initial assessment, screening and stabilization, to *long term care
- providing short-term assessment, stabilization and respite care, crisis intervention and outreach, as well as non-medical emergency response teams
- developing protocols for the referral and discharge of patients, with the capability to monitor and evaluate the referral and follow-up system
- developing contracts for specific services to meet patient needs, with the capability to monitor performance and the achievement of service standards
- consulting with consumer groups at service levels
- establishing "broadly constituted regional mental health advisory boards to advise regional managers of mental health services of the needs, policies and operation issues for the care of the mentally ill persons in the area"
- promoting inter-ministerial coordination and consultation within the Ministry of Health.

The province is currently developing comprehensive local service plans coordinated through Regional Mental Health Centres. Standard assessment criteria are being used to assess the availability of local services. The plans will be organized at the district level and then be reviewed at a provincial level to determine the programs needed throughout the province. But we think that the assumptions upon which some elements of the *Report's* recommendations are based make the viability of the overall plan questionable.

The *Report* does not discuss how mental health services will attract and retain qualified personnel to staff medium/long-term specialized units, nor does it address how to determine the effectiveness of mental health care services. These two points must be dealt with. ***It is no longer sufficient to provide services and treatment for which there is little or no evidence of positive outcomes***.

For example, the Greater Vancouver Mental Health Service Society is widely regarded as a model community-based mental health service. Yet neither the society nor any other component of the mental health system has been evaluated. Evaluation is absolutely necessary if efficiency and good management are to be achieved. It is an integral part of a managed system of care and must be done using established and consistent criteria.

Therefore, the commission recommends that:

2. **the Ministry of Health evaluate the effectiveness of hospital-based and community-based mental health programs.**
3. **the Auditor General conduct a value for money audit of the Mental Health Services Division.**

A number of other issues must be addressed if mental health services are to become a single system of care.

- Different approaches to the planning, management and delivery of services for different areas of the province.
- The current system for purchasing services encourages limited case follow-up and affects continuity of care.
- Patient "cream-skimming" means that people who have severe problems are often left to the local Mental Health Centre to deal with.
- It is not clear whether standards exist for assessing contracts in terms of program outcomes.
- In the effort to down-size government, little attention has been paid to the cost of achieving savings. The requirement to monitor contracts often competes with service demands at the local level.
- It is generally agreed that approximately 20 percent of all cases require intensive case management and long-term follow-up, yet there is no working definition for case management.
- Data systems are often incompatible, making it impossible for institutions such as Vancouver General Hospital (VGH) and Riverview to communicate electronically.
- Often medical records are not transferred with the patient. This results in the duplication of tests and makes it difficult to discover what therapies have already been provided. The patient record ensures that the patient receives the most appropriate and effective treatment possible. It is the property of the patient and must be part of the treatment and rehabilitation program. ***Physicians and institutions must accept that they do not own a patient's medical record.***

Protocols for the discharge of clients and their transfer between institutions need to be developed. Support services need to be improved, including providing better housing and employment opportunities.

Alternative support services, such as Venture, which provides short-term residential care for the mentally ill adult who is experiencing a crisis, are also necessary. Venture provides observation, assessment, and stabilization as well as social and recreational programs for residents. It helps to divert some individuals from inpatient programs and returns them to the community as quickly as possible.

The gatekeepers of the system, such as general practitioners, social workers, psychologists, and public health workers, need continuing education and support. They must have access to the service delivery system without delay, but problems continue to exist in managing people with acute psychotic episodes. The Greater Vancouver Mental Health Society has attempted to build cooperative links between institutions; however, many hospitals appear reluctant to accept their mandated role of providing acute psychiatric care. The BC Medical Association (BCMA) has suggested that 15 currently closed beds at VGH could be transferred to intensive psychiatric care to replace closed beds at Riverview. This approach should be considered for hospitals with closed beds throughout the province.

Therefore, the commission recommends that:

4. the Ministry of Health, in its role as coordinator and consultant,
  - **a. define the mandate of general and psychiatric hospitals, and the means to link community health centres, hospitals, and other services;**
  - **b. use a functional means to evaluate the operation of the mental health network;**
  - **c. focus on early identification and immediate treatment of mental illness;**
  - **d. develop alternative settings, such as short stay units, for the care and management of the mentally ill;**
  - **e. develop long-range planning capabilities at the regional and provincial level;**
  - **f. increase accountability of the system at the regional and provincial level;**
  - **g. develop multi-year plans and priorities through consultation with community advisory boards;**
  - **h. shift funding priorities from hospital-based programs to community, residential and social support services; and**
  - **i. develop operational program and planning links with other ministries, including Social Services and Housing and the Solicitor General.**

In 1990, there were 376 psychiatrists in BC. There is evidence that many psychiatrists are going into private practice without taking responsibility for the after-hours care of their patients. As a result, a small number of psychiatrists provide emergency services and inpatient treatment for a large number of patients.

Such care is a public service. At a minimum, it should be part of professional responsibilities. Yet neither the Royal College of Physicians and Surgeons nor the Canadian Psychiatric Association requires psychiatrists to provide services in hospitals where there are psychiatric beds. Nor are there rewards for those who do. In fact, psychiatrists who work exclusively in clinics, hospitals, or community service receive up to 30 percent less annual income than do those working exclusively in private practice.

Therefore, the commission recommends that:

5. a. psychiatrists who provide inpatient and emergency services receive remuneration equivalent to those in private practice in the community; and
  - **b. the BC Medical Association, College of Physicians and Surgeons, British Columbia Health Association and Ministry of Health develop standards of practice that include the requirement that psychiatrists in private practice provide hospital services as deemed necessary by the regional general manager.**

Riverview

The impetus for the ***Mental Health Consultation Report*** was the deterioration of Riverview Hospital and Treasury Board's approval to replace the facility. However, it is apparent that, with time, the original objectives as stated in the *Report* have changed and new priorities have developed.

Riverview reached its peak patient population in 1956 with a total of 4,306 patients. Twenty years later there were 1,853 beds, and by February 1985, according to the *Report*, bed capacity was 1,306 (906 in the Adult Division and 400 in the Geriatric Division). At that time, the hospital had a full time staff of 1,654, and a budget of $73 million. The total number of operating beds at Riverview and Valleyview (the geriatric wing of Riverview) is now 907 and the submitted budget is $79 million. The increase is due, in part, to the BC Buildings Corporation transferring responsibility for building and grounds, maintenance and security personnel, contract settlements, payroll and administrative support to the hospital.

It was on the 1985 base of services available in the community that further development of the community mental health system for the "...seriously mentally ill adult and elderly individuals" was to occur. Since then, the Mental Health Services Division's budget has been increased to provide community services, but neither the budget nor the staff of Riverview has substantially decreased and most of the reduction in the patient population occurred prior to the *Report*. It seems unlikely, therefore, that the original $73 million will be transferred into the community as the *Report* proposed. Reductions in variable costs, such as the closure of a unit, will not result in major savings. Savings can only be realized by eliminating both fixed capital costs and variable operating costs. The community system has not been treated as an alternative to the established institution but as an add-on cost.

In February 1990, the government announced the "enhancement" and "redevelopment" of the initiative originally set out in the *Report*. According to the 1990 background report to the Mental Health Plan Implementation Steering Committee, "enhancement" includes:

- extending the time frame for implementing the *Report's* recommendations from five to ten years
- adding $20 million to the base budget of Mental Health Services Division over a three to five year period (1990/91 - 1995/96)
- providing $2.65 million in transitional funds annually for the next 10 years
- 100 percent provincial capital funding, or $60 million, over the next ten years to pay for 110 acute psychiatric beds to replace facilities at Riverview.

According to the Steering Committee, the $20 million for Mental Health Services Division was originally meant to improve the organization and effectiveness of the current system and to move it toward integration with the general health care system. In November 1990, however, the government approved $6 million of this money to address "...the existing critical service deficiencies for 5,000 additional mentally ill individuals." This change in position suggests either a continuing lack of policy direction or a lack of priorities in dealing with known service deficits. In addition, there is no public statement indicating the policy or program objectives to be achieved with the $26.5 million in transitional funds, or what means will be used to assess their effect.

The "redevelopment" plan for Riverview and the mental health system included in 1990:

- an increase from 60 to 170 beds in acute psychiatric inpatient facilities with a corresponding reduction of beds in medium/long-term psychiatric inpatient facilities and community residential beds.
- dropping the plan to shift 300 elderly mentally ill patients to *continuing care. Services for the mentally ill in Riverview's Geriatric Division are to be replaced on "...a bed-for-bed and service-for-service basis as with those for adult patients in the Hospital."
- dropping the base number of beds to be redeveloped at Riverview and elsewhere to 1160 as a result of further de-institutionalization of patients.

Riverview is constantly being bombarded with requests to accept patients who may not necessarily be best served by a referral there.
PRO-127

For a reduction of the Riverview facility to be accomplished, target dates must be established and new tertiary facilities must be built in the districts expected to provide regional services to mentally ill people. The *Report* stated that 550 tertiary care beds would be decentralized. This was subsequently revised to 500 beds, 300 of which were to remain in the Lower Mainland and the rest distributed throughout the province. But no detailed plans exist to accomplish this down-sizing, and interim measures to implement it have not been discussed.

It must be recognized that if there is to be further de-institutionalization, then more money will be needed to fund community services. The government must maintain its commitment to the $20 million enhancement initiative begun in 1990, but the rationale for that money, and the government's specific objectives, must be defined. To date, the government has not provided any assurance that the enhancement monies are either needed or sufficient.

• *The Mandate*

Riverview Hospital's mandate includes providing specialized services to adult and geriatric patients suffering from serious psychiatric disorders who cannot be managed effectively in the community. This population might generally be described as:

- the neurologically damaged who have developed severe behavioural problems
- the mentally retarded with anti-social behavioural problems, psychiatric or physical illnesses
- those with chronic psychoses (approximately one-third of identified schizophrenics)

1989/90 MINISTRY OF HEALTH EXPENDITURES

Program Component	$M	Percent of Total Mental Health Services
Mental Health Services		
- Riverview	84.5	
- Forensic	23.4	
- Grants	43.2	
- Mental Health Centres	16.2	
- Burnaby Psychiatric	5.4	
- Other	7.1	
Total	179.8	36%
Acute Hospitals	132.6	26%
Continuing Care	119.8	24%
Medical Services Plan		
- GP Consultants	16.7	
- Salaried & Sessional Psychiatrists	14.2	
- Fee-for-Service Psychiatrists	31.0	
Total	61.9	12%
Pharmacare	9.5	2%
Total	503.6	100%

Source: Ministry of Health, 1991, Briefing Notes

- individuals with organic degeneration who exhibit extreme behavioural problems or are violent (a large number of demented elderly).

For those who cannot cope or cannot be managed in the community, institutionalization is a reality that must be accepted as part of the overall planning for mental health services in BC.

The role of Riverview must be clearly defined. It must provide backup for *acute care and community services for the difficult patient, and its funding should be solely for this tertiary function. The hospital must provide a teaching and leadership role in the care and management of the type of patients for which it has a mandate. Teaching related to the care and management of acute care and *community care patients should be carried out elsewhere by appropriate community and acute care institutions. Riverview must not be allowed to change its mandate without public consultation, and without coordinating its actions with community services and hospitals. Mandates and funding are discussed in ***Hospitals.***

Woodlands and Colony Farm

Woodlands is a tertiary care facility for the profoundly mentally handicapped who may also have physical handicaps. Since many of the patients in this facility suffer from psychiatric conditions, Woodlands is included in this chapter.

It has been proposed that Woodlands, located in New Westminster and run by the Ministry of Social Services and Housing, be emptied of all those people who are able to be de-institutionalized by 1993. Whether or not this is in the best interests of those people must be determined. An independent assessment of their needs and the effect of environmental change on them is clearly warranted before any further action is taken.

Some communities may not be able to provide appropriate care for people from Woodlands so that some amount of institutional care will still be appropriate in the future for patients who are severely physically and mentally handicapped. Those with long standing psychiatric problems, in particular, could be moved to the *extended care facilities on the Riverview site, possibly to a special long term care unit.

> *If you compare it [Colony Farm], to the old part of Oakalla jail you're being kind. And to treat people who are mentally ill in a facility like that - herd them all together, 26 people in a 13 bedded room with no individual privacy - it really is quite appalling.*
>
> PRO.094

A portion of mentally handicapped people who commit petty offences in the community are currently referred to Forensic Psychiatric Services for assessment. Once they are judged not guilty by reason of insanity, they are held at Colony Farm, a part of the province's service. Riverview is also the appropriate site for these people, and approximately 10 - 15 percent of Riverview's beds may be needed to care for them.

It is the opinion of this commission that, in its present condition, Colony Farm is an unacceptable facility for anyone or for any purpose.

Population projections for the province indicate that BC will need a facility where individuals who cannot be managed in other facilities, including long term care facilities, can be sent. The extent of this tertiary role is difficult to estimate, given changes in patterns of illness and the technology to manage people such as patients with severe dementia or advanced Alzheimer's disease. Care in the community is always the standard for which to strive. However, where hospitalization is necessary to care for the person or protect the public, British Columbians will need to be assured that appropriate facilities are available. Therefore, reconsideration of the future role of the Riverview, Woodlands and Colony Farm facilities and lands is imperative.

Therefore, the commission recommends that:

6. a. the decision to close Woodlands be reviewed and the individuals remaining on site be assessed by independent assessors to determine the optimal environments for them; and

b. the disposition of the lands and building that now constitute Woodlands should not be decided until the review of the independent assessors is complete and a long range mental health plan is tabled for public discussion.

7. the use of the Colony Farm building cease and new facilities be built on the same or a similar site with a separate facility for persons who are sent for assessment pursuant to court orders.

8. the board that is currently responsible for the operation of Riverview Hospital be replaced by a board composed of members of the public as recommended in *The Management of Health Care Services*.

9. the Ministry of Health publish a five-year plan indicating its policy directions, assumptions and long range objectives. The plan shall include

a. strategies to encourage the development of community-based planning bodies;

b. a provincial mental health advisory body;

c. the mandate of Riverview and other tertiary care mental health services;

d. the purpose and use of transitional monies; and

e. a provision for the evaluation of the mental health care system and its components, including the Greater Vancouver Mental Health Service Society.

You can't provide mental health just through the mental health system.
PRO-094

Mental Health Promotion

Population trends and a greater focus on community-based health care will increase the visibility of the mentally ill. The social stigma of mental illness must be addressed, but as long as the mentally ill are found sleeping on the streets and under bridges, the stigma will remain. A reasonable public policy for health must recognize the multiple effects of housing, employment, transportation, friendships and meaningful activities. A major problem is how to use the multiple sources of funding for acute care services, housing, and social services to deal with mental health.

Changes to the provincial Mental Health Act, which is currently under review, will alter how mental health services are provided. But the degree of public acceptance of the mentally ill must increase and the general public must recognize mental illness as a disability if the changes are to be effective.

Mental health is closely linked to social and physical environments.
For example:

- stressful work environments and unemployment adversely affect physical and mental health.

- adverse *prenatal conditions have negative effects on intellectual performance.

Therefore, the commission recommends that:

10. the Ministry of Health develop an information program which will improve both the understanding of mental health and the acceptance of those individuals in the community with mental illness.

In 1986, a Vancouver Health Department survey found that 54 percent of children aged four to five were registered in a licensed preschool program and, in response to this high rate, the Vancouver Health Department developed a pre-school program to provide basic health services such as immunization and vision, hearing and dental screening. In addition, *A Resource Guide for Early Childhood Educators* was developed by the Vancouver Health Department with funding from Health and Welfare Canada's Child Care Initiatives Fund. The purpose of the guide is to help workers identify children with developmental problems and refer them to public health for treatment. Resource materials which help increase the social and physical competencies of children are also provided.

Primary prevention projects during the pre-school years have been shown to have long lasting benefits. But access to licensed programs is limited by availability, cost and location so that those most in need of such programs — single parents and their children — are the least likely to receive them. "Underground" day cares, the last resort for many families, often cannot meet licensing requirements and may even work against improving basic health.

Therefore, the commission recommends that:

11. the Ministry of Health

a. and the Ministry of Social Services and Housing make licensed child care programs available to persons on limited incomes;

b. review licensing requirements so that unlicensed child care programs are encouraged to become licensed and participate in well-organized public health screening and referral programs; and

c. provide dedicated pre-school support services in each public *health unit in the province.

School programs also play an important role in the development of healthy adults. *Toward a State of Esteem: The Final Report of the California Task Force to Promote Self-Esteem and Personal and Social Responsibility* recommends a program which would help develop self-esteem and personal responsibility through:

- the involvement of the family in the school
- the development of family life and parenting skills to promote the self-esteem of parents and children
- information on the effect of child abuse on self-esteem and academic performance
- information on the role of self-esteem in drug abuse, treatment and prevention, and crime and violence.

The BC Ministry of Education has begun to implement its *Learning for Living* curriculum in elementary schools. It is supposed to start in elementary schools in the fall of 1991, and in secondary schools in 1992. However, the delivery of the program requires implementation funding and the support of a wide variety of agencies, such as public health.

The *Learning for Living* program includes four main themes organized around seven content areas: careers, child abuse prevention, family life education, healthy living, mental well being, safety and accident prevention, and substance abuse prevention. The four themes are:

- *Individual awareness and responsibility,* to identify and develop the physical, emotional and spiritual self of the child, and to promote behaviour which supports self-esteem.
- *Relationships,* to develop communication skills and an understanding of types of relationships, roles and changes in relationships.
- *Social awareness and responsibility,* to increase appreciation of the value of cooperation and individual initiative.
- *Life long development,* to focus on the responsibility of the individual as a continual learner, developing skills in adapting to new circumstances and practising attitudes that promote a healthy lifestyle.

Other major parts of *Learning for Living* that are not curriculum-based include healthy school environments and services for students (guidance and health services). Funding of protocols is still required for these two categories. The mental health protocol, intended to provide services to children and young people of school age with severe mental, behavioral and emotional disorders, has not been funded.

The Canada *Youth and AIDS Study,* conducted for Health and Welfare Canada in 1988, showed that the self-esteem of students in BC was lower than that of students in all other provinces. Relationships with parents and friends, and the general emotional state of students also rated lower in BC than the Canadian average. Students in large metropolitan centres rated even lower in these areas.

Therefore, the commission recommends that:

12. the Ministry of Education

  a. establish a selected pilot project for the *Learning for Living* program to determine the program's outcomes for both the general school populations and high risk groups, including children with conduct disorders, affect disorders, and social isolates; and

  b. provide funds to implement the *Learning for Living* program for elementary and secondary schools.

Review of the Mental Health Act

Mental health legislation in most jurisdictions in Canada is now believed to be inconsistent with the Canadian Charter of Rights and Freedoms.

People who are detained as involuntary patients under the current Mental Health Act may automatically lose the right to give or withhold consent to treatment. We believe that such practices are often excessive. Involuntary patients are not necessarily unable to understand information or make health care decisions.

A review of the provincial Mental Health Act is currently being carried out. It will address:

- involuntary admission and detention criteria
- treatment, *informed consent and competence
- confidentiality and access to information
- administrative review
- least restrictive setting.

As care for the mentally ill becomes more diverse and complex, accountability for individual assessment and diagnosis, support and follow-up services must be built into the system of care. But while attention is being directed at informed consent and freedom of information issues, the broader question of management and accountability of the system is not being dealt with in any detail, nor will it be addressed given the parameters of the review.

Therefore, the commission recommends that:

13. a presumption of all legislation, and hence the design of the mental health system, be the least restrictive setting and level of intervention, consistent with standards of quality care. Notwithstanding this presumption, the commission recognizes that there are circumstances in which reasonable grounds exist to believe the individual may be a danger to self or others, and in which legislative authority will be necessary to issue emergency restraining or treatment orders. When such orders are issued they shall be time limited and the issuance of such orders may be appealed by the person affected.

14. there be an early, compulsory review by an independent panel, of any person held under involuntary admission.

15. an annual public report be made of the number of voluntary and involuntary admissions.

16. the principle of continuity of care, including treatment and discharge plans, case management, transfer protocols, and quality improvement programs, must underlie all design elements of legislation and service provision.

17. the Mental Health Services Division

   a. develop explicit standards for care in all types of facilities;

   b. develop a system to measure performance in relation to those standards; and

   c. provide appropriate financial rewards for institutions providing high quality care.

* GLOSSARY

The Guardianship Committee is also reviewing legislation relating to consent to treatment and substitute decision making. While the government review apparently recognizes the committee's initiatives, it sees overlap in only two areas:

1.
Adults in need of protection because of abuse,
neglect or self-neglect,
including a mentally ill person
neglecting him or herself but who is not
dangerous to others.

2.
Consent to medical care for incompetent adults
which may include definition
of mental competence
(or incompetence)
and the appointment
of an associate decision maker or guardian.

Although, by and large, mentally ill people are not a threat to themselves or society, a very high number of people with some illnesses – for example, schizophrenia – do commit suicide. This usually occurs when the person does not take medication.

Forcing people to take medication "for their own good" is contrary to the beliefs of many people. But the commission heard from and agrees with a number of groups and individuals that some form of legislation must be in place to help these severely ill people, their families and their communities cope with these tragic diseases.

I'm 48 years old. I was abused as a child.
I was self diagnosed manic depressive
after a suicide attempt when I was 15.
I was formally diagnosed when I was 21.
I've been through lots of depression,
lots of manic episodes,
a number of involuntary committals -
always secluded or isolated during those.
During career counselling a couple of years back
I found that I had started my life from nothing
eight times to get back on track.
The last manic episode I had was in 1986
and during that episode I lost my job,
my car, the apartment.
It took me a couple of years
in and out of debt to put it together,
and I'm still trying to recover from the debt from that.
I lost all of those things.
And after the state paid perhaps
$12,000 of taxpayers money
to treat my mania I was discharged
in poverty into a community
that was experiencing Expo, and found myself living,
once more, in a skid row type of building
in New Westminster across from the post office,
where drunks passed out and urinated in the hallways
- when they weren't vomiting;
where hookers get into fights and drug deals went on.
Rooms were regularly and frequently broken into,
to the extent that regulars like myself
had extra locks on our doors
and the janitor distributed 1 1/2 foot long wooden
clubs to defend ourselves in case
someone broke into the room while we were sleeping
or in the room. Happily I never had to use mine.
I don't think that's anyone's idea of health care
and yet, in fact, its part of the continuum
of health care.
It's the income end of it,
the poverty end of it.
SOC-198

HIV AND AIDS

It is important to distinguish between infection with Human Immunodeficiency Virus (HIV) and its most severe clinical outcome, Acquired Immune Deficiency Syndrome (AIDS).

- HIV is a communicable virus which leads to AIDS.
- AIDS is a clinical state of immune deficiency associated with a number of diseases. AIDS is fatal.

HIV/AIDS is a world-wide problem. In some areas of the globe, nearly half of the population is infected with the virus, or has AIDS. These extreme infection patterns may even occur in Canada in some groups or sub-cultures, such as intravenous drug users, people with a high number of sexual contacts, some isolated Native reserves, and street youth. HIV/AIDS respects no borders.

There is no more lead time.
Actions are needed now.
NAT-027

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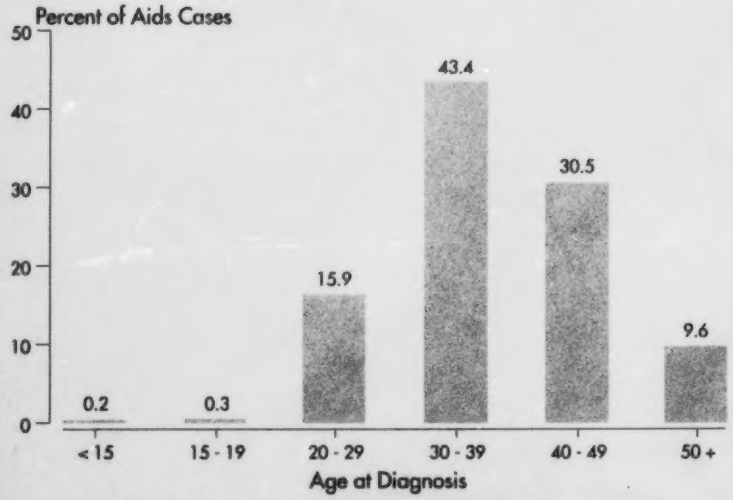
BC has always had the highest AIDS rate in Canada.

- As of December 31, 1990, a total of 862 cases of AIDS had been reported in BC with another 95 cases anticipated but not counted because of reporting delays.
- As of February 1991, BC had a cumulative rate of 276 cases for every one million people.
- 98 percent of the cases reported in BC occurred in men, 2 percent in women (the national rate for females is 5 to 6 percent).
- 92.3 percent of the male cases were homosexuals or bisexuals.
- 3.3 percent of the male cases were homosexuals and injection drug users.
- More than 85 percent of all the reported cases in the province were in the Lower Mainland (Vancouver, North Shore, Burnaby, Richmond, Simon Fraser, and Boundary Health Units) with 74 percent of reported cases in Vancouver.
- 15.9 percent of all cases were diagnosed at ages 20-29, 43.4 percent at ages 30-39 and 30.5 percent at ages 40-49.

AIDS CASES IN BC BY AGE AS OF DECEMBER 31, 1990



Source: Rush J, Rekart ML. AIDS Update Quarterly Report - Winter 1990. BC Ministry of Health. December 1990

The Natural History of HIV/AIDS

The HIV/AIDS incubation period is the interval between HIV infection and AIDS diagnosis. There are three major stages within the incubation period. The fourth stage of the disease's natural history includes AIDS.

Stage I: The infection may be accompanied by a flu-like illness, one to two weeks after exposure. ***There is an unknown period of time between infection with HIV and the point at which antibodies develop and can be detected by an antibody test***. This period may range from three months to several years.

Stages II and III: The majority of people currently infected with HIV are in this intermediate phase. They feel healthy and the virus is relatively inactive; a large proportion of these people may be unaware that they carry HIV.

In 1989, a BC/Yukon survey of 22,512 anonymous blood specimens from pregnant women showed that one in 1,300 women between the ages of 15 and 29 in metropolitan areas in BC was infected. This suggests that up to 400 women in BC are HIV infected. But because the test population was low-risk, the actual prevalence of HIV in the province is probably much higher.

Stage IV: AIDS has several subclassifications:

- wasting syndrome
- neurological disease
- opportunistic infections
- cancers.

Common conditions among AIDS sufferers include Pneumocystis carinii which occurs in 65 to 80 percent of all AIDS patients in North America, and Kaposi's sarcoma which occurs in 10 to 20 percent of cases.

The commission stresses that ***the natural history of HIV infection appears to be much longer than first thought***. The latent period may last three to seven years, followed by a mild, moderately symptomatic period which can last another three to seven years. People with AIDS may live another one to five years after that. For most people, though, the length of time from HIV infection to AIDS is now thought to be approximately 12 years, and survival following the diagnosis of AIDS, a further two years. ***The median survival time from infection is therefore approximately 14 years***.

The Transmission of HIV

HIV is transmitted primarily by unprotected vaginal or anal intercourse, sharing contaminated needles, or perinatally from mother to offspring.

The transmission of HIV by sexual contact can be stopped if infected people avoid unprotected anal, vaginal or oral intercourse. There is no risk of sexual transmission for those people who practice sexual abstinence or if neither partner is infected. Couples who have been mutually monogamous since the introduction of HIV in North America in the mid-1970s are not at risk. People who have sex outside of mutually monogamous relationships can reduce their risk by limiting the number of sexual partners they have, selecting low or no-risk partners and practising safe sex.

Safe sex is sexual activity where partners do not exchange semen, vaginal fluid, or blood. Safe sex includes kissing, if no oral lesions are present, hugging, caressing and genital manipulation if no skin lesions are present. Vaginal and rectal intercourse are safe if a latex condom is worn and if it does not fail. Latex condoms have been shown to be effective barriers to viruses, including HIV, but failures do occur.

Other sexually transmitted diseases (STDs) can enhance the efficiency of HIV transmission, and people at high risk for other STDs are automatically at high risk for HIV. These include:

- people with multiple sexual partners
- prostitutes
- street youth.

Therefore, the commission recommends that:

1. **the BC Centre for Disease Control expand and support aggressive prevention and treatment programs for all sexually transmitted diseases.**
2. **legislation require escort agencies to provide latex condoms, as well as education and counselling on sexually transmitted diseases, to their employees.**

As is true for every infectious disease, the spread of HIV infection involves the transmission of an organism from an infected reservoir to an uninfected host. Strategies to prevent infections can, therefore, be directed at the reservoir, the host, or the means of transmission.

There's nothing
more difficult
than trying
to change behavior,
and I think
that's probably
particularly true
when it comes
to sexual behavior.
SOC-266

Since there is no vaccine currently available to protect an uninfected host, the best strategies for controlling the spread of HIV/AIDS are:

- HIV testing and counselling
- partner notification
- donor referral and donor screening to eliminate HIV-infected organs, tissue, semen and blood
- the proper and consistent use of latex condoms
- using spermicides with latex condoms to to kill the virus
- counselling and support of infected people and people at risk
- practicing safe sex
- avoiding intravenous drug use (IDU)
- avoiding sharing needles
- sterilizing needles
- preventing or terminating pregnancy in HIV-infected women
- preventing breast feeding by HIV-infected women
- practicing Universal Precautions procedures to protect health care workers from exposure to blood and certain body fluids, to reduce or avoid needle sticks and to reduce or avoid the likelihood of transmission of HIV during invasive medical procedures.

The effectiveness of prevention strategies can only be judged according to the extent of behaviour-change in the at-risk population and, ultimately, by the reduction in infections and deaths. No other measure is acceptable.

Therefore, the commission recommends that:

3. a. latex condoms and instructions in their proper use be made available to institutionalized and incarcerated persons;

b. vending machines dispensing latex condoms in men's and women's washrooms be a condition of licensing for drinking establishments; and

c. vending machines dispensing latex condoms be placed in high schools throughout the province.

Since the second major transmission route for HIV/AIDS is intravenous drug use, addicted people should be encouraged to enter rehabilitation programs. Educational programs directed toward teenagers, drug-users and the staff of drug clinics must emphasize the danger of sharing drug paraphernalia.

• *Needle Sharing*

The Vancouver Intravenous Drug User Intervention Project is an example of an effective HIV control program. This program has substantially changed needle sharing behaviour in Vancouver and has stabilized the infection rate among intravenous drug users at 3 percent for the past three years. This rate is lower than in metropolitan areas without such programs.

Therefore, the commission recommends that:

4. comprehensive intervention programs for injection drug users include education, testing, counselling, needle exchange, *'teach and bleach', latex condom distribution, addiction treatment, and social support; and be implemented in major metropolitan areas and provincial and federal jails.

Sexual activity among Canadian adolescents is estimated at 18 percent among 15 year olds and 66 percent among 19 year olds. And adolescents are experimenting with drugs at an increasingly early age. They are at risk.

Therefore, the commission recommends that:

5. appropriate family life education be made available at every grade in every school.

• *Transplant and Artificial Insemination*

The prevention of HIV transmission through blood and blood products, transplantation and artificial insemination has been dramatically successful. However, there is still some danger because of the use of non-medically supervised artificial insemination, and because of the Stage I period of infection when the HIV antibody cannot be detected.

• *Mother to Child Transmission*

The number of *perinatal HIV transmissions is very low in BC. However, education and counselling of prospective parents about HIV transmission, including transmission by breast feeding, is valuable and necessary.

Therefore, the commission recommends that:

6. pregnant women be tested for HIV, and HIV infected persons be counselled about the possible consequences of bearing children and of breast feeding.

Prevention

The spread of HIV/AIDS can be reduced through population-based strategies which use news media and the schools to teach the general public about the importance of avoiding infection. HIV screening, and tracing sexual contacts within target groups, are other effective approaches.

• *The Population Approach*

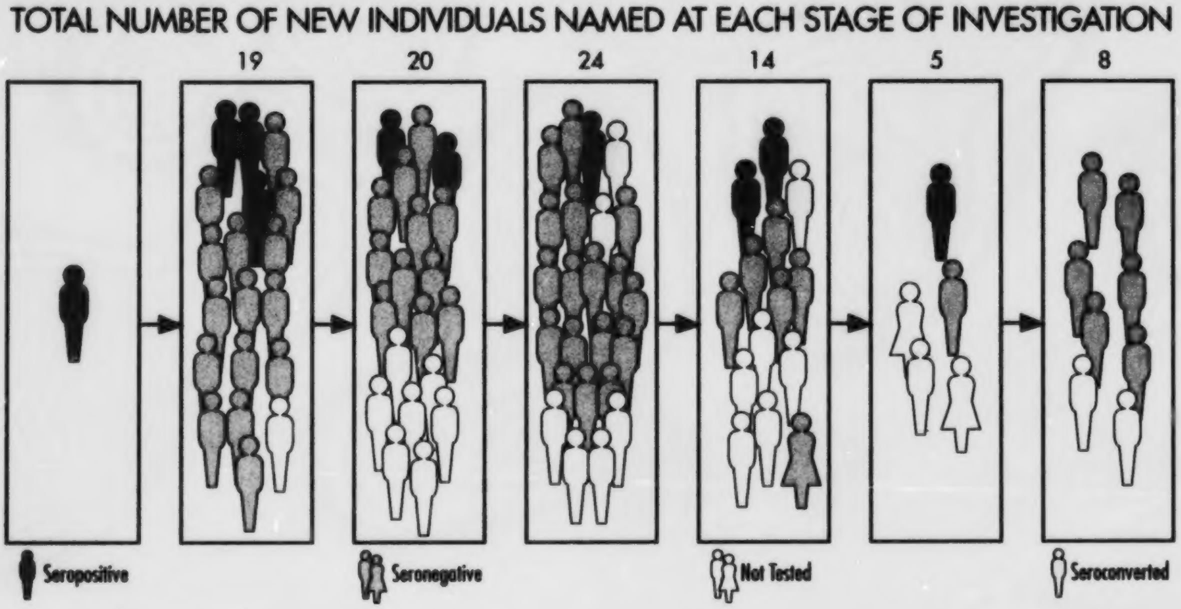
Population-based prevention strategies focus on improving the level of knowledge in the general public, or in major groups such as children and adolescents, by telling them about ways to reduce the risk of infection and encouraging them to adopt them. The ability of population-based programs to change the social behaviour of individuals and groups is important to long range prevention. Word-of-mouth education is especially successful in sub-populations, such as communities of homosexual males.

In 1987, the *Canada Youth and AIDS Survey* showed that the majority of young people aged 12 to 21 knew about AIDS and how it is transmitted. BC youth scored higher than those from other provinces while street youth and dropouts scored even higher.

A 1988 survey of 1,259 Canadian adults also showed that virtually all Canadians knew about AIDS: about 90 percent gave a reasonably accurate description of the disease and how it is transmitted. Homosexuals were among the most knowledgeable, often understanding as much, or more, than their health care providers. Injection drug users and prostitutes also have high levels of information, especially about transmission and protection. However, there is very little culturally appropriate or effective information for ethnic and Native communities.

I think the only thing that's operative against AIDS is education.
NAT-029

*** GLOSSARY**



Partner notification programs can be highly productive, as illustrated by results of a South Carolina investigation that began with one HIV positive man. Of the 19 sexual contacts he named, all but one were tested, and three were seropositive. Those three then named 20 sexual contacts not already identified, leading to discovery of two more HIV positive men, who in turn named 24 other previously unidentified contacts, and so forth. When the investigation reached its end point of no new HIV positive contacts, it had identified a total of 90 persons at risk, tested 68 of them, and found 12 who either were seropositive or seroconverted six months after initial testing.

Source: Hospital Practice - December 1990

Information does not necessarily change sexual behaviour. Education must be repeated, reinforced and personalized.

- About 54 percent of adult men and 41 percent of adult women, interviewed in the 1988 survey, reported changing their sexual behaviour to avoid AIDS. Seventy percent reduced the number of sexual partners.

But at the same time:

- only about 15 percent of Canadian university students used condoms consistently, although 70 percent of them knew condoms could protect them against HIV
- 44 percent of men never use a condom; 62 percent of women have sexual relations without using a condom.

• *The Target Group Approach*

This approach identifies high-risk populations and promotes voluntary testing and identification as prevention strategies.

- Screening identifies HIV-infected people who are not aware of the infection. Antibody testing is applied to people at risk or to people who have a high potential to infect others, for example, pregnant women or blood and transplant donors.

- Contact tracing and partner notification uses information from HIV-infected people to find and inform those people whom they have exposed to HIV. Notification, education and support help the infected person to decide to prevent the further spread of the disease.

The commission has been told that contact tracing is cost-effective and we expect it will become vital once a treatment or vaccine for HIV is developed.

The result of an HIV test itself may affect a person's behaviour. People who test positive tend to change their behaviour to protect others, especially if there is ongoing counselling and support. However, people who test positive can also react angrily, threatening to 'get back at' the society within which they were infected. Others may reject safe behaviour since they themselves can no longer be hurt. These reactions are usually temporary and not acted upon, and are usually replaced with responsible behaviour. A negative result after definite exposures may also give a false sense of protection to some people.

Being identified as HIV positive can wreak havoc in a person's personal and professional life. It can lead to discrimination in housing, employment, recreation, insurance and health care, and if people do not feel confident that their privacy will be protected, they will be much less likely to cooperate in prevention programs. Confidentiality is a critical component in controlling the spread of HIV.

The Canadian Federal Centre for AIDS Working Group on Anonymous Unlinked HIV Seroprevalence recommends the use of anonymous unlinked methodology in Canadian studies to determine the prevalence of HIV in the population. They cite the costs of locating and testing contacts as a rationale against partner notification, but they are not clear about what the costs are for not tracing contacts, or what the net benefit is to society if there is no notification.

In Colorado, a number of tests have been added to the list of automatically reported laboratory results. Complete patient information is provided with the results, but it is subject to strict laws governing release of the information and is further protected from subpoena, search warrant, or other legal means to circumvent confidentiality. California, by way of contrast, has complete anonymity in testing. Yet, during a three-year period in which HIV testing increased in both states, Colorado had 41 percent more voluntary tests than California.

The advantage of the Colorado approach is that it permits more accurate tracking of HIV infection. It also offers more effective notification and follow-up of the 10 to 15 percent of people who fail to show up for counselling after an HIV positive test. In addition, it is possible to quickly and discreetly advise infected people about new treatments as they become available.

Therefore, the commission recommends that:

7. the province of BC

  a. implement a confidential contact tracing and partner notification program for HIV/AIDS; and

  b. control access to the records and prohibit the issuing of orders permitting access to the records.

I would like the WCB to recognize AIDS as an occupational health risk for emergency care providers.
IND-246

• *Mandatory Testing*

The National Advisory Committee on AIDS has recommended against mandatory testing. It is concerned about patient rights and argues that calls for mandatory testing ignore the relatively small risk of HIV infection, the effectiveness of Universal Precautions procedures and the potential for social, economic and psychological harm to the patient.

The Canadian Medical Association is also opposed to routine testing of hospital patients. It feels that the implementing of Universal Precautions is adequate to protect both patients and health care workers, and recommends that sufficient funds be provided to cover the increased costs required in their use.

However, a US study of inner city hospitals found that:

> *Compared with actual testing for evidence of HIV infection, it is clear that the risk concept, when used so as to affect significantly a woman's perinatal care and that of her child, is a dubious and unreliable tool.*

Self-reporting and interviews in this study failed to identify 42 percent of the women with HIV antibodies.

Therefore, the commission recommends that:

8. **hospitals and other major treatment centres may test for HIV and communicable diseases such as hepatitis B for hospital workers and patients involved in invasive procedures.**

• *Professional Disclosure*

Most arguments against disclosure to patients by HIV-infected health care workers emphasize the minimal statistical risk of infection, and the harm that disclosure could do to the worker. The Canadian Dental Association clearly states that if dentists follow procedures, the risk to the patient is minimal or nil. The Canadian Medical Association assumes that HIV positive physicians will voluntarily consult their provincial College for advice on what procedures they may and may not safely perform, thereby reducing risks to the patient.

But there is a general obligation in health care that patients be told everything that a reasonable and prudent person would want to know about a procedure. ***We believe that to make an informed decision, the patient is entitled to be informed.***

Therefore, the commission recommends that:

9. **HIV positive health care workers involved in procedures which pose the slightest risk to the patient must inform the patient, notify the appropriate regulatory body and avoid any procedures which may place the patient at any risk.**

Current AIDS Prevention Programs in BC

The prevention strategy of the province includes free testing and counselling, public education and information, and outreach programs including the needle exchange program. The Native awareness and prevention program includes support for posters, videos and forums in Native villages. While a coordinator has been hired for the program, the money allocated to this area does not match the potential problem.

The Sexually Transmitted Disease Control Branch within the BC Centre for Disease Control of the Ministry of Health administers or participates in most prevention programs in the province. These include:

- Family Life Education Curriculum for schools through the Ministry of Education
- government employee programs through the Ministry of Finance and Corporate Relations
- alcohol and drug programs through the Ministry of Labour and Consumer Services
- prison programs through the Ministry of the Solicitor General.

Some municipalities administer AIDS prevention programs, and community groups such as AIDS Vancouver, AIDS Vancouver Island and the Persons with AIDS (PWA) Society, participate in prevention through specific programs, general awareness and public functions. Other non-profit groups which attempt to prevent AIDS among their constituencies include the BC Coalition of Persons with Disabilities and the Vancouver Native Friendship Centre. AIDS education, support and prevention efforts have also been initiated by the various health professions. No one knows how often professionals take the opportunity to educate people about HIV/AIDS, but the opportunities are almost certainly under used.

Because of the long incubation period from HIV infection to AIDS, the results of the prevention programs started between 1985-1990 will not be known until the last half of this decade. However, studies among homosexual men have already shown significant increases in safe sex and decreases in new infections.

An interim measure of the effectiveness of these programs in changing sexual behaviour is the diagnoses of other STDs, especially those with short incubation periods and those that are legally reportable. In BC, gonorrhea diagnoses have decreased from more than 10,000 in 1980 to 1,328 in 1989. Newly acquired syphilis has also decreased, especially among homosexuals. Syphilis, gonorrhea and other sexually transmitted diseases are discussed in ***Public Policies for Health.***

• *St. Paul's Hospital*

We think that people who are found to be HIV positive, or who are identified through contact tracing, should be informed quickly about available counselling and treatments. It is critical that HIV/AIDS patients benefit from the latest developments in treatment and therapy.

By virtue of its geographical location in the West End of downtown Vancouver, St. Paul's Hospital has been the main referral centre for more than 75 percent of the province's AIDS cases. St. Paul's has carried out this responsibility very well. Its Infectious Disease Clinic (IDC) has become a major *tertiary care centre and it could play a valuable role in linking HIV/AIDS patients throughout the province. Having IDC personnel report directly to the family physician has already expanded the number of HIV-educated *primary care physicians in the province.

Therefore, the commission recommends that:

10. a. a financial incentive for primary and specialty clinical care of persons with HIV/AIDS be included in the *fee-for-service Schedule to encourage treatment and prevention counselling;

b. clinical fellowships in HIV/AIDS care for family practitioners and specialists be used to increase the number of clinicians in BC with HIV/AIDS expertise;

c. training in HIV/AIDS care be a component for all health care professions; and

d. a program of continuing education be established for clinicians to gain expertise in HIV/AIDS care.

The average length of stay for AIDS patients at St. Paul's Hospital is 12.5 days; the average cumulative use of hospital beds from diagnosis to death is 50 days. Nursing care for AIDS patients in acute medical units at St. Paul's has been estimated at 9.8 hours for each day. This is lower than the estimated hours of care at the Royal Victoria Hospital, Montreal, and the Montreal General Hospital. The AIDS outpatient clinic, opened at St. Paul's hospital in 1987, handles more than 1200 patient visits per month and has certainly helped contain inpatient hospital demands.

• **Home Care and* **Palliative Care*

Approximately 20 percent of AIDS patients die at home. The Continuing Care Program of the Vancouver Health Department began caring for 12 to 15 people with AIDS a month in 1988, but that number has steadily climbed and is now about 90 people a month. This increase is largely due to the expanded role of Long Term Care *homemakers who help people with AIDS with household tasks and personal care.

Earlier diagnosis and treatment, increased longevity and outpatient care and decreased volunteer and caregiver support all bear upon this commission's recommendations for increased home care and *continuing care and a reduction in the *acute care sector. Staying at home during the prolonged terminal phase represents a substantial savings in hospital days and should be encouraged wherever it meets the patient's need for high quality care. But, if people are to be cared for at home rather than in hospital, the province will have to remove disincentives such as the equipment and medication costs described in ***Prescription Drugs*** and ***Palliative Care***. The BC AIDS Network brief and the *HIV/AIDS Housing and Care Consultation Report to the Assistant Ministers Committee on Service Policy* have highlighted the need for appropriate housing for people with HIV or AIDS.

Both St. Paul's Hospital and the Vancouver Health Department provide hospice or palliative AIDS care. Short-term home care, facilities for severely demented patients and increased homemaker support would decrease end-stage hospitalization.

• *Chronic Acute Care in HIV/AIDS*

Currently, final admission to hospital includes an average of 20.7 acute medical and palliative care days. Final admission patients require help and may be completely unable to care for themselves.

Therefore, the commission recommends that:

11. support programs be developed, including rehabilitation centres, sheltered housing, and group homes for specific populations such as women with children, Natives, injection drug users, transient youth, transsexuals, and individuals with pre-existing psychiatric disorders.

AZT

HIV/AIDS is a complicated illness and people with moderate to advanced HIV disease tend to undergo several treatments. These are often costly and may lead to drug toxicity.

Early aggressive drug therapy is now the trend in treatment for people with HIV in the hope of deterring or even preventing AIDS. So far only AZT (Zidovudine, Retrovir, Azidothymidine) prolongs the life of patients with advanced HIV disease. AZT can also prolong the symptom-free interval in patients with less advanced HIV. Early intervention, particularly as safer drugs are developed, will therefore continue, and become the standard therapeutic approach in the near future.

The Financial Cost of HIV/AIDS

The financial cost of an illness is evaluated in terms of direct and indirect costs. Direct costs are for personal and non-personal medical care. Indirect costs are a measure of lost productivity.

Personal medical care includes funding for hospital and physician services, drug treatments, outpatient ancillary services, nursing homes, hospices, and home care. These costs are high in the case of HIV/AIDS. Non-personal costs include monies for research, health education, blood and organ supplies, management changes, Universal Precautions and other support services.

Direct medical costs for treating HIV/AIDS patients have fallen dramatically in the last four years, from an estimated $82,000 to approximately $50,000 for each person. This downward trend reflects the tendency for patients to be able to remain in the community with the help of aggressive outpatient management and prophylactic regimens.

In 1987, the Royal Society of Canada conservatively estimated the indirect costs of HIV/AIDS to be $300,000 to $800,000 for each person. This estimate is restricted to people with full-blown AIDS and does not account for early interventions.

People with HIV/AIDS experience serious economic and housing problems throughout the course of the disease. A 1986-1990 review of 325 AIDS patients showed that 53 percent were on income assistance at the time of diagnosis. As more of the marginal segments of society with fewer personal resources, such as injection drug users, street youth and prostitutes, form more of the patient population, the need for support services and housing will rise.

While numerous organizations and volunteers provide a great deal of support, how long this will continue is uncertain. The conventional health care and social service systems will face increasing demands if there is a high rate of volunteer burnout.

The recent statistics
from the federal centre
for AIDS
says that
there are 24
aboriginal people
in Canada
that they know of
that have AIDS.
Well,
on the 100 block
of East Hasting
we know of
36 aboriginal people
that are
HIV positive
or
have AIDS.
NAT-029

HIV/AIDS in BC

Approximately 5,000 to 6,000 people in British Columbia have HIV infection. Most of these people will become ill with-in the next decade, requiring $250 - $300 million worth of provincial health care services. This estimate assumes no further HIV infections, so the true cost is far higher.

A strong argument in favour of a vigorous HIV/AIDS prevention program can be made. Unlike reducing risk factors for cancer, ***every case of HIV infection that is prevented will avert a case of AIDS***.

The commission believes that effective programs can and should be instituted. Dramatic downturns in the infection rate among homosexual men show that relatively inexpensive community-based education will work. Inexpensive needle exchange programs have already lowered rates of intravenous drug use transmission and can bring many people into treatment. Latex condoms are simple, cheap and generally effective, especially in conjunction with spermicides. Explicit AIDS education can provide low cost benefits.

But the provincial and federal governments, and the general public, must be absolutely clear about the severity of the threat presented by HIV/AIDS.

- There is a large pool of *unaware* individuals in the general population whose period of latency may be longer than researchers originally thought. This presents a major public health problem that our current public health control practices do not adequately address.
- The transmission of HIV is much more likely among certain high risk groups, especially the Native population. Intravenous drug use, sexual abuse and multiple sexual partners are high among Natives, yet AIDS prevention programs designed for this group are inconsequential. The high extent of other sexually

transmitted diseases and the mobility of the Native population from urban areas to reserves dramatically increase infection rates. ***It was only one hundred years ago that the Native peoples of BC were devastated by smallpox. All of us must be aware that the potential now exists for another fatal epidemic to sweep through this community with consequences for the whole of society***.

- Although infection control programs for intravenous drug users, street youth, and prostitutes are reasonably successful, funding cuts, detrimental program changes, or real or perceived breaks in confidentiality could lead to a rapid spread of HIV infection among these sub-groups.
- Currently, there is no routine way to monitor HIV infection during the latency period and the rate of infection in this period is not known. If the rate is high, or if it increases without being detected, the long-term effects for society are difficult to contemplate.

Therefore, the commission recommends that:

12. a. the Ministry of Health develop a screening program which has as broad an application as practicable to determine and monitor the extent and spread of HIV. Possible screening programs include:
  - **i. random, periodic surveys of the general population;**
  - **ii. seroprevalence studies of leftover biologic samples; and**
  - **iii. screening at point of contact with the health care system; and**

b. where HIV infection is found, the individual receive appropriate counselling and support, and contact tracing be initiated.

13. the Chief Native Advisor, Native Health, with the cooperation of Native groups, institute periodic voluntary screening of Native groups willing to cooperate, and implement prevention and control programs.

14. voluntary HIV testing programs be expanded to include remote and institutionalized populations.

15. the BC Centre for Excellence in HIV and related viral diseases that is being established at St. Pauls Hospital
  - **a. evaluate the degree of reporting delay and under-reporting and devise mechanisms to minimize these deficiencies;**
  - **b. survey the knowledge and behaviour of health care professionals; and**
  - **c. monitor the direct and indirect costs of HIV/AIDS in BC.**

We're sitting on a ticking time bomb.
NAT-024

DIAGNOSTIC IMAGING SERVICES

The purchase and operation of computed tomography (CT) scanners and magnetic resonance imaging (MRI) units has caught the public's attention. But ultimately, the issue raised by these diagnostic imaging services is no different than that raised by any other service or procedure in the health care system: ***tax dollars must be spent on providing the best quality care in the most cost-efficient manner possible.*** The effect of any technology on a patient's physical and mental health should always outweigh the economic and social costs of providing that technology.

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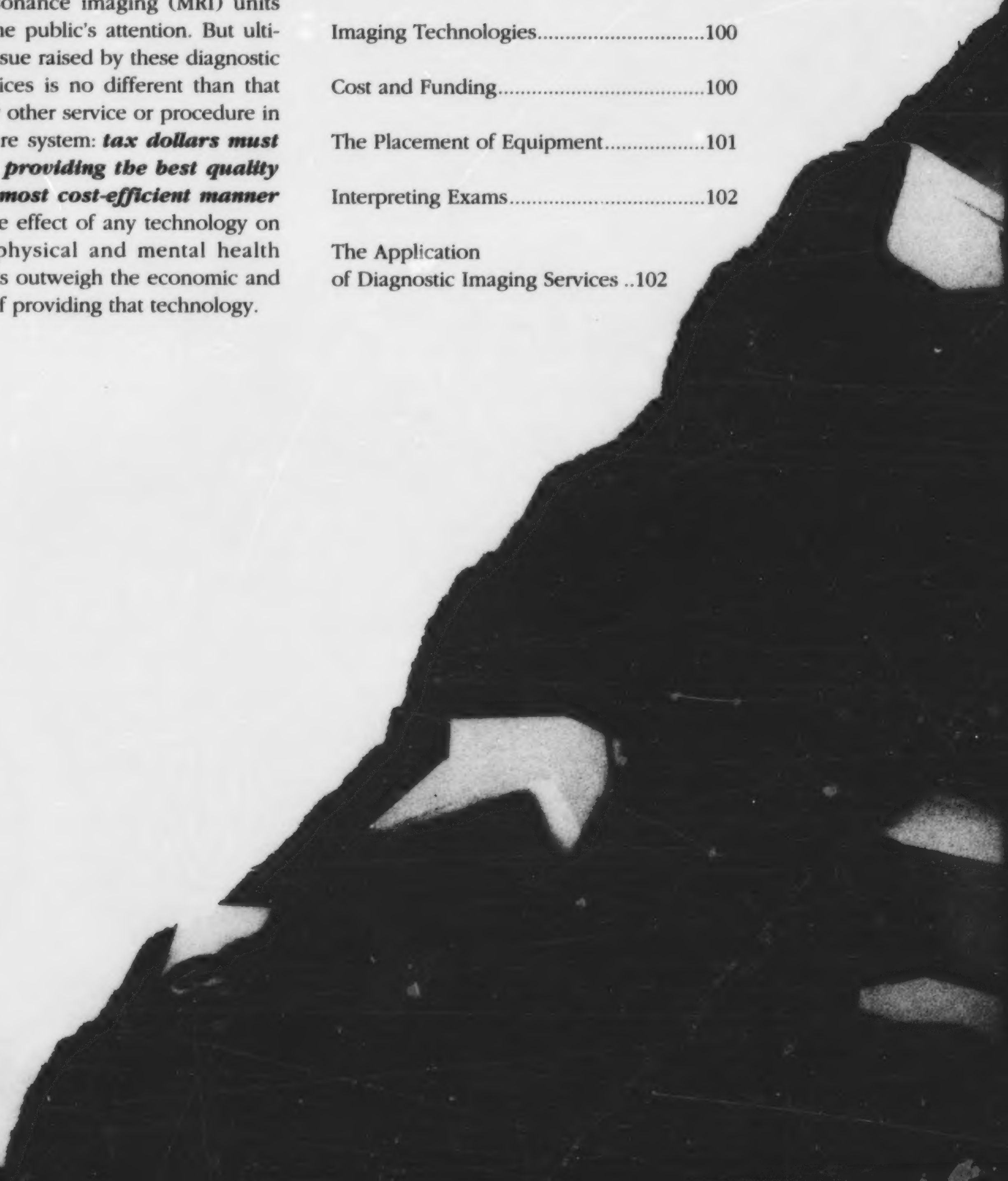

CT scanners and MRI units are the diagnostic imaging services most commonly discussed in the news media — they are innovative, high-tech machines, surrounded by a Star Trek-like mystique. But imaging services also include mammography, ultrasound, and the oldest and most common form of imaging, radiology or x-ray. Because they are much more common and because of the potentially harmful effects of radiation, more attention needs to be focused on the cost and quality of these low technology services.

Imaging Technologies

> *I think it's going to be extremely difficult to resist technology which can provide a better picture of what is wrong with a patient. If MRI produces a better picture than CT, then, clearly, the shift will be towards MRI.*
> HOS-066

Radiology: Developed in 1895 by Wilhelm Konrad Rontgen, radiology, or x-ray, was the first medical imaging technology. X rays are electromagnetic radiation which pass through the body, leaving shadows caused by the different densities of tissue and bone on film. The images left by X rays are usually stored mechanically. Both computed tomography and mammography are based on X rays.

Computed Tomography: CT scanners produce high resolution pictures of bone or soft tissue. This is done through the use of computers to digitize, store and generate X ray images.

Mammography: X rays are sent through the patient's breast to provide information about the physical properties of the breast tissues.

Sonography/Ultrasound: Based on sonar technology developed in the Second World War, sonographic computers scan the echoes of high frequency sound waves to produce images of the tissues reflecting the sound. Ultrasound is most commonly associated with investigations of the foetus, the gallbladder, cardiac anatomy and reproductive organs.

Magnetic Resonance Imaging: MRI scanners collect information on tissue through the use of radio waves and a magnetic field tens of thousands of times more powerful than the earth's magnetic field. Based on the properties of hydrogen nuclei in water molecules, MRIs do not "see" bone or teeth and can, therefore, look at tissue surrounded by bone.

Cost and Funding

Although the costs per exam and costs per machine are much less than with CTs or MRIs, the frequent use of x-rays — almost two million exams in 1989/90 compared with 96,000 CT scans and 1,100 MRI exams — makes this the most important diagnostic imaging service. Operating costs of radiology services provided in the community were $57 million in 1989/90, and at least that much for services provided within hospitals. Unfortunately, the Ministry of Health does not know the cost of x-ray services in hospitals.

The purchase price of CT scanners is up to $1 million and MRI units are $4.5 million. The annual operating cost of each machine is an additional $500,000 to $1 million

All capital equipment is funded as follows:

Capital Costs

- Less than $100,000 - The sole responsibility of the hospital. Block funding for this equipment is allocated to hospitals on the basis of their role and bed size.
- More than $100,000 - Subject to approval, the Ministry of Health contributes 60 percent of the costs. The remaining 40 percent is the responsibility of the *regional hospital district and/or the hospital foundation.

- Provincial Referral Services and Programs - Subject to approval, the Ministry of Health contributes 100 percent.

Operating Costs:

- In seeking approval for the capital costs of equipment, the hospital may also seek funding for the operating costs.

The Placement of Equipment

The placement and use of diagnostic imaging services in BC should be based on allocating money to those services which offer the greatest health benefit to British Columbians for the dollars spent. Unfortunately, placement is not the result of comprehensive technology assessment — the process of measuring costs and benefits discussed in ***The Best Care*** — and many other factors are allowed to influence it.

The Continuing Advisory Subcommittee on Medical Imaging, composed of members of the BC Medical Association and the College of Physicians and Surgeons, develops guidelines to help the ministry decide the placement, maintenance, and renewal of medical imaging equipment. The subcommittee considers such factors as the capital and operating costs of the service, the levels of staff and expertise required to operate the service, and the size and mobility of the population. Although one of the principles of the subcommittee is to reduce political interference in the distribution of imaging equipment, politically motivated decisions still continue.

The Ministry of Health has recently begun a two-year evaluation of the use, costs and benefits of the MRI units at the Greater Victoria Hospital Society, Vancouver General Hospital and University Hospital (UBC Site) to establish the relationship between the use of MRI technology and *health outcomes. Although the evaluation is not complete, the ministry has already announced that both St. Paul's Hospital and Children's Hospital will receive funding for MRI units.

The rationale behind this announcement appears questionable. Vancouver General Hospital's MRI unit, which is situated within three kilometers of both St. Paul's and Children's Hospitals, is used only eight hours a day, four days a week, although the hospital has told the commission that it could provide a second shift for one-half the cost of the first shift. Running MRIs day and night, seven days a week, as is currently done in Australia, is probably a more cost-effective solution than purchasing another unit.

It's financial idiocy to spend $3 million plus to open an MRI facility, and then tell you you're going to run it four days a week on one shift.
SOC-059

Under the current structure, the Ministry of Health will never be able to prevent political influences from affecting the placement of diagnostic imaging services. While the Ministry of Health needs to retain control of *tertiary equipment, control of non-tertiary diagnostic imaging equipment should rest with the regional general manager.

Therefore, the commission recommends that:

1. **the Ministry of Health continue to decide on and fund tertiary diagnostic imaging services and publish the information used to make those decisions.**
2. **funding for capital and operating costs of non-tertiary diagnostic imaging equipment be within the regional funding envelopes.**
3. **newly developed diagnostic imaging services be evaluated at a provincial centre.**

Even without the initial approval of the Ministry of Health, the public purse often bears the expense of diagnostic imaging services. Communities anxious to have their own imaging equipment — usually stimulated by physicians or hospital representatives — can simply raise the complete capital cost themselves. Four communities are currently in the process of raising funds for CT scanners, and the ministry will be under considerable pressure to pay for the operation of this equipment if it is purchased, a much more substantial expense than the initial capital cost.

In ***The Management of Health Care Services,*** we recommend that a regional general manager be responsible for budgeting within each provincial region. That would include budgeting for capital and operating costs of non-tertiary diagnostic imaging equipment which would be done with the assistance of guidelines from the BC Office of Health Care Evaluation and various local community groups. In ***Careful Spending,*** we recommend that hospitals could share the use of equipment on a time share basis so that control of the equipment rests with the guest hospital for the contracted period of time.

Interpreting Exams

Radiologists are currently required to report on every x-ray exam. Although their expertise is often required, and quality control demands sample checking, there appear to be some instances where a report is unnecessary, or where a physician would have sufficient skill to report on the exam.

Inappropriate reporting by radiologists can occur when:

- the x-rays, which have been transferred to another physician or facility, are returned several weeks or months later
- the patient dies between taking and reading the x-rays
- the patient breaks a bone, has an x-ray, is given a cast and sent home before the x-ray is read
- the referring specialists have the necessary expertise to interpret x-rays relevant to their specialty.

Therefore, the commission recommends that:

4. radiologists not be required to report on x-rays in which the radiologist's report does not have the potential to change the treatment of the patient.

The Application of Diagnostic Imaging Services

The commission has been told that a significant portion of the diagnostic imaging exams provided in BC is unnecessary. They neither change the treatment the patient receives nor affect the patient's recovery. Providing unnecessary diagnostic imaging not only wastes money which may have been spent elsewhere, but also puts people through unnecessary risk and discomfort and delays patients with real needs from receiving exams.

It is important that expensive and limited high-tech diagnostic imaging equipment, such as MRIs and CTs, is used appropriately. But we are also concerned about the inappropriate use of low-technology equipment. X-ray equipment is widely accessible and x-rays are relatively cheap for each exam. Because of this, there is the potential to order an excessive number of x-rays, affecting overall costs and raising concerns about the harmful effects of radiation.

Some examples of unnecessary exams which have come to our attention include:

- using ultrasound as a screening tool in *all* pregnancies when several national consensus panels have advised against its use in normal pregnancies
- providing CT scans upon demand, without ensuring appropriate indications for a scan
- repeating x-rays when the results will not change the patient's treatment
- providing routine x-rays for admission to *intermediate care facilities.

The decision to request an exam is based on a physician's judgement of a patient's clinical needs. But it is difficult for the physician to make this judgement without a comprehensive knowledge of the effectiveness of diagnostic imaging exams. As a result, decisions are made inconsistently and diagnostic services are provided for inappropriate reasons. There is also an incentive for a radiologist to suggest performing exams, as they are done on a *fee-for-service basis which results in a direct payment to the radiologist.

The commission is of the view that salaried radiologists could better exercise the restraint that is now lacking in the ordering of x-rays.

Therefore, the commission recommends that:

5. **the BC Office of Health Care Evaluation develop guidelines in consultation with radiologists and local advisory boards for the use of diagnostic imaging services.**
6. **a radiologist (preferably a salaried radiologist) be responsible for disseminating and ensuring compliance with the guidelines.**

As a physician
I know that
the CT scan,
the MRI,
frequently just substantiates
a suspicion or diagnosis
that we're all very aware of.
HCP-187

C-104

LABORATORY SERVICES

Clinical laboratory services are a major component of the BC health care system. They have become increasingly important in helping physicians to reach a diagnosis and monitor therapy. Their share of payments by the Medical Services Plan (MSP) is also increasing. In 1974/75, laboratory services made up 9 percent of all fee payments for medical services; in 1989/90 they made up 13.6 percent or $135.6 million. In the past 15 years, payments for laboratories have risen nearly 60 percent faster than those for all other medical services.

After adjusting for general inflation there has been some, but relatively little, increase in the costs of each test. The primary factor underlying the growth in both inpatient and outpatient laboratory costs has been the increasing volume of tests ordered and performed. The most extreme example of this is high density lipoprotein testing – cholesterol screening – which increased by 1,326 percent between 1979/80 and 1988/89. The fee increase over this period was 51.1 percent, similar to the general inflation rate.

The increase in test volumes has also been far greater than can be explained by increases in the size and age of the population or, in the case of in-hospital tests, by increases in the number of inpatients treated. This trend raises a number of critical questions. Are physicians who order increasing numbers of tests gaining a corresponding increase in information about their patients? And is there a corresponding improvement in the speed and accuracy of diagnosis, and in the effectiveness of therapy?

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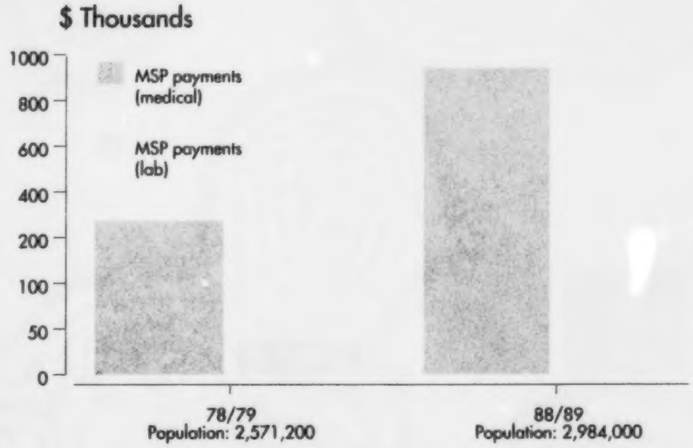
> *If you increase uncertainty in the system,*
> *either through more rapid throughput,*
> *or having physicians see patients*
> *for too short a period of time,*
> *the tendency is to increase the number*
> *of tests they order.*
> HOS-169

There is a potential for conflict of interest situations where pathologists both work for the hospital and have an interest in a private lab.
UNI-002

Over one half of the outpatient laboratory services in BC are provided by privately owned laboratories. Although a number of small laboratories are owned by individual physicians or small groups, the private sector is dominated by three large companies. Public laboratories, which are primarily hospital-based, also include Red Cross laboratories and the Provincial Laboratory.

Payments to private laboratories are made up of fees charged for each individual test. These fees are part of the general fee schedule negotiated between the BC Medical Association (BCMA) and the Ministry of Health. Hospital laboratories are funded as part of the global budgets to public facilities or, in the case of the Red Cross and the Provincial Laboratory, through annual grants. Outpatient services provided by hospital laboratories are paid by MSP on the same fee schedule as private laboratories. The payments go to the hospital, however, not to the laboratory, and they may be taken into account in determining the overall budget allocation from the ministry to a hospital.

FIGURE 1
COMPARATIVE LABORATORY STATISTICS
(1978/79/1988/89)



Source: Operations Review Branch, British Columbia Ministry of Health, Laboratory Review, January 1990

Under the Medical Services Act, laboratories providing insured diagnostic services for outpatients in BC must be approved by the Medical Services Commission. The Certificate of Approval issued by the Commission identifies the range of tests for which a laboratory may be paid, at present defined as Category I, IIA, IIB, IIC or III tests. In this way, the certificate acts as both license and mandate for the laboratory. Tests not covered under the fee schedule, such as *cytology, *surgical pathology, *virology, and some *immunology, are not provided by private laboratories. The actual number of tests which dominate the workload of the private sector is surprisingly small: 77.4 percent of the total revenues are generated by only 30 tests.

The Medical Services Commission interprets the Act as requiring private laboratories in BC to be owned by a physician. The Ministry of Health has distinguished *vested-interest* laboratories from other private laboratories for a number of years. In 1990 it added a further distinction: *conflict of interest.*

- *Private laboratories* are owned in whole or in part by a physician, and carry out diagnostic tests for patients referred by other physicians.
- *Vested-interest laboratories* are owned in whole or in part by a physician who carries out diagnostic tests for his or her own patients or who receives material benefit from referring to the facility.
- *Conflict of interest laboratories* are owned in whole or in part by a physician who is also employed as laboratory director or supervisor of a public diagnostic facility of the same classification which is located within a reasonable referral distance.

Laboratory Costs

The 1990 Laboratory Review by the Operational Review Branch of the Ministry of Health reports that between 1978/79 and 1988/89, payments for laboratory services rose more than 20 percent faster than other fee payments for medical services. But the trend is not uniform. Laboratory services reached a peak of 13.8 percent of MSP payments in 1983/4, then during the next five years their costs rose roughly in line with total fee payments.

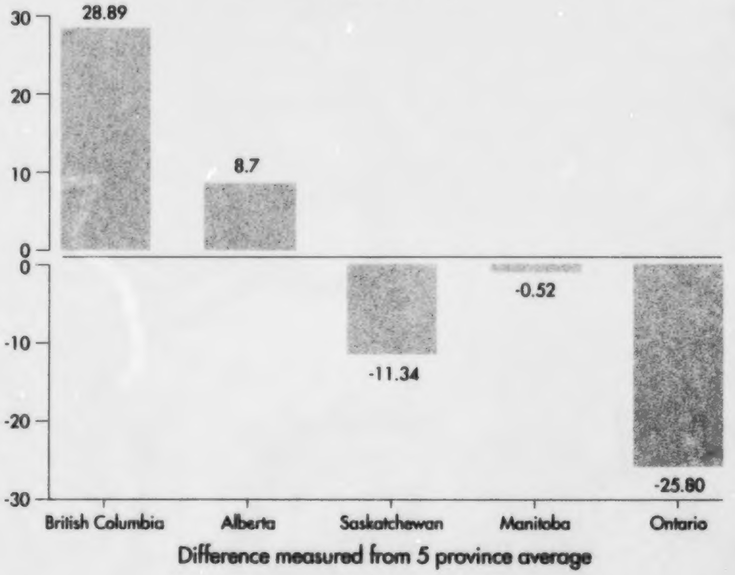
Although MSP payments to hospitals do not necessarily reflect the actual costs of providing particular tests in hospital to inpatients and outpatients, the commission was provided with laboratory cost data for the period from 1971 to 1990/91 by one of the province's major teaching hospitals. These data show a pattern similar to the MSP data: a very rapid increase into the early 1980s, with much slower growth thereafter. However, they also show growth accelerating again after 1988/89, the latest year covered by published MSP payment data. Unpublished MSP data for 1989/90 also points to a resurgence in growth: total MSP payments for laboratories in that year were $135.6 million, 7.9 percent above their 1988/89 level. Payments for Category II and III tests were up by 12.9 percent.

• *The Components of Costs*

Laboratory costs, like all costs based on *fee-for-service or unit cost, are equal to the total number of units provided multiplied by their average price. There is some evidence, however, that the unit costs may be higher than necessary in BC, and that the financial returns from laboratory services are above average, particularly when the fact that the industry is relatively low-risk is taken into account.

A study of fees paid for the province's 17 most frequently ordered laboratory tests shows that compared to Alberta, Saskatchewan, Manitoba and Ontario, BC has the highest fees for eight tests, the second highest for six, and the third highest fees for three. Figure 2 shows that fees for these 17 tests are, on average, 29 percent higher in BC than the corresponding averages for the five provinces. BC's fees are nearly 75 percent above those in Ontario. All of these provinces pay for private and hospital outpatient laboratory services on a fee-for-service basis. *The Comparison of Fee-for-Service Pathology, Regulation, Utilization and Costs: BC versus Western Canada and Ontario, 1989,* by the Policy and Planning Division of the Ministry of Health found 'no legislative differences with British Columbia vis-a-vis the four other provinces examined, which could successfully explain the cost differentials for laboratory services.'

FIGURE 2
AVERAGE PERCENT DIFFERENCES IN FEES FOR 17 MOST FREQUENT LABORATORY TESTS MARCH, 1991



Source: Operations Review Branch, British Columbia Ministry of Health; January 1990

* GLOSSARY

The premium paid for fee-for-service pathology in British Columbia is an economic rather than a legislative phenomenon, as the fees are determined by negotiation between the Medical Services Plan and the British Columbia Medical Association. The fact that the British Columbia fees are the highest in Canada is the direct result of successive sets of negotiations.

THE 1989 PROVINCIAL COMPARISON, POLICY AND PLANNING DIVISION, MINISTRY OF HEALTH

The fee paid for each test can be allocated among three components of a laboratory's costs:

- indirect component – costs of specimen collection, patient documentation, transportation, indirect labour and other overhead
- technical component – cost of technician and scientist time
- professional component – the cost of *pathologist time.

Indirect costs are generally estimated to make up about 60 percent of the cost. The fee schedule, however, only distinguishes between professional and technical components and combines both indirect costs and non-professional time into the technical component.

• *The Technical Component*

Most of the fee for a laboratory test goes to pay for the technicians and other personnel engaged in actually carrying out the test, and to the indirect costs of laboratory operation. Therefore, the fees for different tests should reflect the relative costs of performing them. This is commonly referred to as a relative-value-based fee system. The major variable, labour, is measured in workload units where one unit equals one minute of technician, clerical or aide time with adjustments for a number of factors.

The present BC fee schedule does not have a relative-value basis, but the Laboratory Review recommends adopting one for fee negotiations. Ontario, Nova Scotia and Quebec have already successfully adopted the relative-value basis for rationally determining laboratory fees, and Alberta is currently exploring it.

• *The Professional Component*

The assumption that each test provided by a laboratory represents a service provided by a physician is the basis for including laboratory services in the MSP fee schedule. The amount calculated to be the professional component in each fee item varies widely, ranging from 12 percent for simple tests to 40 percent for complex, pathologist performed tests. The overall average is approximately 13 percent, indicating that most tests are simple.

Although the professional component is nominally to pay for professional services, pathologists in private and public laboratories are not, in fact, paid directly by MSP. Instead, the whole fee is paid to the laboratory, and pathologists negotiate their payments with the laboratory's owner on a fee-for-service, salary, or sessional rate. According to the Laboratory Review, just over half of the hospital pathologists in the Lower Mainland were paid by salary and the rest were paid on a fee-for-service basis.

While some tests are actually performed by pathologists, most are not. They are routine, mechanized tests performed by an aide, technologist or scientific staff person, with no participation by a pathologist at all. In the same way, most of the professional cost component does not, in fact, go to pathologists.

In 1988/89, MSP spent $18.2 million (estimated) for the professional component of laboratory costs. This was about 14.5 percent of total laboratory billings, split almost equally between Categories I and II, and Category III tests. Of this $18.2 million (estimated), about $11.2 million went to private laboratories, but only $3.3 million was actually paid to pathologists in private labs. The remaining $7.9 million remained with the laboratory owners.

A similar process occurs in hospitals. Indeed, smaller hospitals with minimal pathologist coverage are paid the full professional component.

This means that a significant proportion of the money paid for each laboratory test is designated for professional services which are either not provided or not paid for. Therefore, it could be concluded that laboratories are being paid too much.

Attempts to provide a rational basis for the professional component were first made in 1978. But the BCMA resisted any change to the fee structure at that time and it remains an unchallenged component in the fee-for-service schedule in BC. Currently, neither the BCMA nor the Ministry of Health places a high priority on resolving the anomalies in the present schedule. But we think that fairness to other physicians and the taxpayers demands a revisit of this issue. In ***Health Care Personnel***, we recommend that an independent board study issues arising from the fee schedule.

Role of the Referring Physician

The commission has been told that the province has an excellent level of laboratory quality control through the work of the Diagnostic Accreditation Program, a joint committee of the BCMA, and the College of Physicians and Surgeons. But a number of concerns have been expressed to us, by pathologists among others, about the extent of repetitive, duplicative, and unnecessary testing.

According to *Technology Diffusion: The troll under the bridge, a Pilot Study of Low and High Health Technology in British Columbia (June 1990)*, which studied tests paid for by MSP,

> *Laboratory services in B.C. for 1979/80, 1983/84, and 1987/88 show a consistent pattern of referral by physician specialty. General practitioners referred most frequently for laboratory tests (approximately 80% of laboratory tests ordered in all three periods) while internal medicine (about 11%), general surgery (2% - 4%) and urology (1% - 2%) ranked consistently behind.*

There are no restrictions on physicians ordering any test in the fee schedule. A hospital might place some restrictions on use of the hospital laboratory, but the commission has not been told of any. There is no systematic audit of the ordering patterns by either individual physicians or particular groups, yet batteries of tests with no evidence of value to the patient's health may be repeated on a regular basis. The regular monitoring of physicians' billings through the Patterns of Practice Committee might identify physicians whose ordering behaviour is radically different from their peers, but laboratory use is not the focus of the committee.

The Diagnostic Accreditation Program grants accreditation to laboratories. The Program focuses its attention on whether laboratories meet organizational and funding requirements as set out by the profession and it appears to succeed in this task.

But the Program makes no effort to assess the appropriateness of test ordering patterns, or the clinical effect, relative use, or cost effectiveness of tests. It is essential that test results be reliable, but it is equally important that the tests be appropriate to the patient's condition. Reliable answers to irrelevant or repetitive questions do not add to information or contribute to improved health care outcomes.

In other provinces, professional colleges have begun to develop protocols which specify what tests should be performed in what circumstances and in what sequence. As the statutory body responsible for regulating the profession, a college can link appropriate testing behaviour to its standards of practice. In Manitoba, for example, the College of Physicians and Surgeons plays a dominant role in guiding information between government and physicians about acceptable protocols. This has effectively reduced routine ordering of a number of tests which have been clearly demonstrated to be of little clinical use. We understand that the colleges in Ontario, Saskatchewan, and Alberta are also moving in this direction.

Developing testing protocols has created a certain amount of strain between the colleges in the other provinces and their respective membership promotion associations. This is understandable. The colleges, as described more fully in ***The Governance of the Health Care Professions***, are responsible for protecting the public, and the associations for the economic and other interests of their members. However, the associations are important to the success of any attempt to change the patterns of practice of their members. They are the most efficient and credible groups to communicate information about requirements to comply with emerging protocols.

An example of a test which cries out for such protocol development is cholesterol screening, mentioned in the opening to this chapter. The explosive increases in ordering this test are occurring despite clear recommendations from the Canadian Task Force on the Periodic Health Examination that only high-risk individuals should be tested, since there is little value in mass screening of the non-high-risk population.

Some physicians have told the commission that they face considerable pressure from their patients for this test, presumably as a result of its promotion in the media. But such pressures are even more reason for the development of a formal protocol. If scare stories lead patients to demand tests against medical advice, then such tests clearly fall outside the definition of medical necessity and should not be paid for by MSP.

BC has lagged behind in developing testing protocols, although there have been some good examples at specific hospitals. The lack of approved protocols or specific requirements for test ordering on the part of the referring physicians is a major contributor to unnecessary use and costs. The current Diagnostic Accreditation Program is not an appropriate regulatory mechanism for overseeing physician referral patterns and testing protocols to ensure appropriate quality testing, and its members have shown no interest in doing so.

Therefore, the commission recommends that:

1. **a. the Ministry of Health and the College of Physicians and Surgeons develop protocols describing when, how, and how often to order particular tests; and**
    b. test ordering which does not meet these protocols not be paid for by MSP.

The absence of a regulatory framework for monitoring, evaluating, and modifying the behaviour of referring physicians in BC has also allowed vested-interest and conflict of interest laboratories to develop and persist. We believe that this is unethical, and a potential threat to the quality of care, quite apart from its being an obvious incentive to escalate test volumes and therefore costs. It must be stopped.

Therefore, the commission recommends that:

2. **the College of Physicians and Surgeons establish, as an ethical standard, that physicians may not order tests from a laboratory in which they have a direct or indirect financial or material interest.**
3. **the Medical Services Plan not reimburse laboratories for tests ordered by a physician who receives any indirect or direct financial benefit from the test.**

Both ethical and financial exceptions may be made for specific laboratories operating in rural and remote areas, if there is inadequate access to an independent laboratory.

The commission considered recommending that series or panel test ordering be stopped, and that all physicians be required to request each test individually. We have been told that this requirement has had the effect of reducing unnecessary test ordering in some of the larger managed care systems in the United States, and it has apparently been accepted by physicians as they have come to understand its purpose and observe its effects. We are concerned, though, that this requirement would be too time consuming for physicians if it were to be applied province-wide. It might, however, be considered by individual hospital laboratories. We support the trend toward simplified requisition forms – currently in use in the Royal Columbian Hospital – which force physicians to order each test individually.

Role of the Pathologist

Several *submissions to the commission by professional groups and the medical school expressed concern that there may now, or in the future, be a serious shortage of pathologists. We believe that this concern is misplaced. There are vacant posts for pathologists which take a considerable amount of time to fill. But vacancies are part of a use-driven system which automatically links the need for pathologists to the expanding volume of laboratory tests being carried out. As in nursing and in many other fields of health care, vacancies do not equal shortages.

* GLOSSARY

The role of the pathologist is central to both setting the fee for each test and appropriate test ordering. But, at present, the tasks pathologists actually carry out on a regular basis often differ from their described functions and from the real needs of the health care system.

The modern laboratory is characterized by a high degree of task delegation and automation – not only automated testing, but also workload measurement, employee performance and other managerial tasks. Therefore, pathologists no longer need to be directly involved in quality control, nor in technical, fiscal or other management functions, except for clinical tests.

We have been told that there is a clear distinction between managing a clinical laboratory and directing one. We believe that it is not necessary for clinical laboratories to be managed by pathologists, and indeed that they do not have any special expertise in doing so, at least not on the basis of their clinical training and qualifications.

In the light of current trends in technology and medicine, a pathologist's tasks should include:

- Establishing criteria, predicting outcomes and evaluating tests in particular clinical circumstances.
- Performing and interpreting tests which require specific expertise, such as interpreting bone marrow specimens, evaluating surgical pathology (including rapid section), performing autopsies, cytology analysis, and complex tests in general.
- Consulting with other clinicians on cases involving review of laboratory data.
- Collaborating with clinicians, particularly clinical chiefs of departments, to carry out *utilization management programs.
- Teaching students and physicians about the need for appropriate and effective testing, as well as performing research directed at improving the use of laboratory services.

There are very few tests which actually have to be performed by a pathologist. In fact, pathologists very rarely supervise tests directly at bench level and are seldom in a position to engage in utilization management, at least with respect to outpatient testing. Specific pathologist functions such as autopsies, which are generally recognized as very important for maintaining and improving the overall quality of medical care, are much less frequently performed than in the past. The actual management of quality control in the laboratory is usually carried out by a senior technician.

In essence, pathologists perform two fundamentally distinct functions. They provide services to laboratories, which include the performance and interpretation of certain types of tests, and general clinical direction and oversight. But they also provide services to the general community, in the form of consultation and teaching for other medical practitioners and, through the laboratory itself, in quality control over the practice of medicine.

In the present regulatory and payment system, pathologists cannot do quality control without threatening their own incomes. The revenues of the laboratory depend on volume and the pathologist's income is derived from those revenues. This places the pathologist in the same situation as a community pharmacist whose pharmacological knowledge cannot influence the prescribing process, and who is paid in proportion to the total volume of drugs used, regardless of whether the prescription was appropriate or not.

The hospital-based pathologist, like the hospital-based pharmacist, is the exception. Apparently hospital-based pathologists do monitor the testing of inpatients, and provide teaching and consultation on appropriate laboratory use to their colleagues. But hospital laboratories are funded out of overall hospital budgets and there is no financial incentive to increase test volumes.

Outpatient testing is paid for by MSP and this puts the hospital in exactly the same position as any other owner of a laboratory. More testing means more money. Therefore, hospital pathologists do not monitor or discourage tests for outpatients.

These incentives, created by fee-for-service, can distort patterns of practice in hospital laboratories as well as in private ones. We have been told that in some hospitals, pathologists have had difficulty performing such critical activities as tissue review and autopsy because of inadequate funding. *Clinical chemistry and *haematology tests provide a larger margin of revenue over costs than does *anatomical pathology. But rather than returning this surplus to the hospital laboratory to support anatomical pathology, hospital administrators may simply retain it in the general budget. Or the Ministry of Health may recapture it by removing some portion of a hospital laboratory's MSP revenue from the hospital's budget. In either case, the authority that controls funding places pressure on the laboratory to concentrate its resources on the most profitable activities. These services should be provided by a pathologist who is not financially or otherwise dependent upon the other members of a hospital's medical staff. The activities and findings of the pathologist should be reported regularly to the hospital's board of trustees, and to the Medical Services Commission.

The Ownership of Laboratories

The Medical Services Commission has generally interpreted the Medical Services Act and Medical Practitioners Act to mean that only physicians may own laboratories. But we can find nothing in the Medical Services Act to support this interpretation. A non-physician is quite capable of managing the daily operations of a laboratory, and that is, in fact, exactly what happens at present. A pathologist must be available to provide clinical expertise as required. But we believe that laboratories are, in reality, business enterprises, and should be treated as such, rather than as medical practices. On the other hand, it has also been pointed out to us that rigid and comprehensive regulations will lead to unnecessary work and costs. Not all surgically removed tissue needs to be analyzed; not all in-hospital deaths can be used to teach lessons in autopsy. Provincial standards to indicate when such investigations are appropriate should be developed by the Ministry of Health in consultation with specialists in pathology.

> *"Now as I suggested we feel that the tests could*
> *be done for approximately $30.00 per sample*
> *and so the government would be saving 20%*
> *or more of that cost, which is one million or you know,*
> *close to a half million dollars a year, just based on*
> *the urine testing itself."*
>
> *"Do you think the owners of the labs make*
> *that much profit from $20.00 to $54.00?"*
>
> *"I don't know if it's a matter of profit as much*
> *as an overhead and a fee that you're paying*
> *for a pathologist,"*
>
> *"But the pathologist doesn't look at it."*
>
> *"That's exactly my point...*
> *When I ask the MSP about the possibility*
> *of getting a license, I was told that in order to bill MSP*
> *you would have to be classified as a category 3 lab,*
> *which has to be owned by a pathologist,*
> *so you're looking at $80,000 [or] $90,000 a year*
> *just to pay a pathologist to own a lab...*
> *when I talked to the MSP, I was told ...*
> *even if a license was approved...*
> *would still have to bill them for $54.00..."*
>
> SOC-238

Therefore, the commission recommends that:

4. the Medical Services Commission no longer require that clinical laboratories be owned and managed by physicians.
5. a. payments for laboratory services be removed from the fee schedule negotiated between the BCMA and the Ministry of Health;
   b. laboratory services paid for by the Medical Services Plan be provided pursuant to contracts which will provide for an approved level of quality and timeliness; and
   c. such contracts shall specify those laboratory tests or other services requiring performance, oversight, or interpretation by a pathologist, and shall include payment sufficient to enable the laboratory to obtain the services of a pathologist.
6. the performance of large scale routine testing be contracted out to private or public laboratories on a competitive basis recognizing the need to maintain competition and to meet an approved level of quality. The development, introduction and performance of complex testing requiring medical interpretation should be carried out in hospital and reference laboratories within a regionalized laboratory system.
7. hospitals be required to provide, as essential pathology services,
   a. autopsies of in-hospital deaths as specified by protocol;
   b. analysis of surgically removed tissue, except where excluded by protocol; and
   c. monitoring and control of in-hospital infection. Hospitals and reference laboratories should continue to be directed by a pathologist.
8. contracts with hospitals include some form of volume-based reimbursement for anatomical pathology services.
9. the Medical Services Commission, and the regional general managers, when they assume responsibility, contract with pathologists to ensure the appropriateness of patterns of test ordering by
   a. assessing the patterns and sequences of testing carried out for particular patients or particular clinical problems;
   b. assisting with the development and dissemination of protocols;
   c. advising on and assisting in the introduction of new tests and procedures; and
   d. consulting and teaching on patterns of laboratory utilization.

A pathologist retained to review testing patterns at the regional level might also provide the more general pathology oversight services in local hospitals and laboratories. Pathologists would then be responsible for overseeing the medical care of populations, not just the performance of individual tests. And if that is their responsibility, then that is also what they must be paid for. A description of the nature and operation of regional funding envelopes can be found in ***The Management of Health Care Services***.

The intent of our recommendations is not to withdraw resources* from the practice of the medical specialty of pathology. On the contrary, we believe that the traditional role of the pathologist as someone who provides information to help the diagnostic and therapeutic process, and as an evaluator and controller of that process, is as important as it ever was. But the present system of organizing and paying for pathology services has pushed pathologists into becoming laboratory managers, financially dependent upon maintaining a high volume of tests.

It is foolish and wasteful to devote an increasing amount of money to the performance of larger and larger numbers of routine laboratory tests that have questionable value, while restricting funding for potentially effective sources of utilization management and quality control. Therefore, we have recommended that individual tests be removed from the fee schedule, and that the professional component of fees go, on contract, to defined pathology services.

An intermediate step in this process might be to remove those tests which do not actually involve the pathologist, and to increase the professional fees for those things, such as anatomical pathology, which do require their expertise. Even when these services are provided for hospital inpatients, and not reimbursed by MSP, we are told that the listed fee has a bearing upon the resources made available for their performance. Increasing, and perhaps actually paying those fees might encourage more frequent performance of autopsies. In addition, hospital mandates, discussed in ***Hospitals,*** could require hospitals to maintain some minimal autopsy rate.

Accessibility and Availability

No organized regional planning exists for the range or distribution of laboratory services. Services are distributed according to arrangements made by individual physicians and supported through government funding.

According to *A Pilot Study of Low and High Technology in British Columbia*, about three-quarters of all laboratory tests in BC in 1979/80, 1983/84, and 1987/88 were ordered from metropolitan areas. Yet the metropolitan areas contain just over half the population.

This is a reflection of the distribution of hospitals and physicians in the province being skewed toward the metropolitan areas. The usual explanation is that services in metropolitan areas are provided to severely ill patients referred in from all over the province. But ***residents of non-metropolitan regions actually receive a lower level of specialty services of all kinds***.

* GLOSSARY

Any physician may be approved for reimbursement for running laboratories that perform Category I tests. Such physician laboratories are not accredited, however, and may be forced to discontinue operation in the face of an increased emphasis on utilization management and quality control in health care. But in areas with limited access to more sophisticated facilities, a better approach might be to offer the physicians operating these laboratories assistance with improving the quality of their service.

One hospital may see the laboratory as a cost centre, one may see it as a service centre, and one may see it as a profit centre.
PRO-021

Black box technologies, which offer "nearer the patient" testing, may permit better access and improved quality standards in rural and remote BC. Such technology currently provides automated testing for approximately twenty items – all Category I and some Category II – through a compact machine that can be located in any physician's office.

The range of tests to which this 'box' technology can be applied is certain to grow over time, probably quite rapidly. However, open-ended fee-for-service payments for tests executed by such equipment would be inappropriate and would make the system's current problems much worse.

Therefore, the commission recommends that:

10. laboratory services be coordinated on a regional basis.

11. subject to review of reliability and quality control, the Medical Services Commission explore the benefit of providing certain physicians with "black box" testing equipment, and reimbursing the operating costs.

Utilization Analysis and Data Management

As in many other fields of health care, the analysis of laboratory services has been limited by weak data. The tracking of fee items within the province and comparisons between provinces are complicated by poor definitions of profiles and tests. Simple analyses which the commission requested and which should be ongoing had to be undertaken as 'one-off' projects.

The ownership of laboratories is poorly recorded. Hospital inpatient work is poorly recorded. Data collection is poorly organized.

There must be a single database or a set of fully comprehensive databases which would include:

- the name, location, license and ownership of all laboratories
- the nature of contractual or other relationships between laboratories, pathologists and other physicians
- a complete listing of equipment and personnel available in each laboratory
- information on each test performed, including:
  - ordering physician
  - identity of patient
  - problem for which test was ordered
  - type of test
  - work unit value
  - site of and payment for specimen collection and testing.

An electronic network should be established to quickly transmit test results and to inform physicians about testing protocols and their use in utilization management and quality control. This network would permit the tracking of patients through the course of an illness, so as to identify duplication and gaps in laboratory work. This is critical not only to show the scale of such problems but, more importantly, to show how and where they arise, and how they can be remedied.

Therefore, the commission recommends that:

12. a database incorporating all laboratory segments be established and maintained in a current status.

13. an electronic network be established based on personal computers in physicians' offices and laboratories, perhaps in conjunction with emerging technology such as the patient-carried smart card systems suggested for other services.

14. the Ministry of Health adopt the recommendations of the Operational Review Branch with respect to filing of copies of laboratory accreditation reports with the Medical Services Commission, and maintenance of medical supervision data.

15. all laboratories, public and private, be subject to periodic audits carried out for the Medical Services Commission by pathologists having no direct or indirect administrative or financial connection with the laboratory, to ensure that the standards for licensure and reimbursement, established by the Commission, are being met.

C-118

PRESCRIPTION DRUGS

Throughout our discussions on prescription drugs we have been guided by three basic principles.

- For drug therapy to be clinically appropriate:
    a. the potential for an increase in the *health status of the person must outweigh the risk of harm; and
    b. the decision to prescribe or dispense a drug should be made with the knowledge of the complete medical needs and drug regimen of the person.
- Drug therapy should be provided to the residents of BC at the lowest cost necessary to meet their needs.
- No resident of BC should be denied access to drug therapy because of an inability to afford treatment.

After listening to the concerns of British Columbians, the commission has come to the conclusion that these principles are not being met. We believe that there is an opportunity here for the province to improve the quality of care associated with prescription drug use, and to save millions of dollars on drug therapy.

Drug therapy is the most frequently used medical modality.
PRO-007

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Pharmacare

Prescription drugs are paid for by the public as out-of-pocket expenses, by their taxes through the Pharmacare and Hospital Programs of the provincial government, and by private insurance. Hospitals spend approximately $100 million or 4 percent of their budgets on drugs, and over 1.8 million residents are eligible for some drug benefits through private health insurance plans.

The Pharmacare program spent approximately $214 million in 1989 providing complete or partial coverage to residents of the province. Unfortunately, Pharmacare is unable to specify the number of medications which each claimant receives; that is, a senior receiving 12 prescriptions may be taking one drug filled 12 times throughout the year, or may be taking four different drugs refilled three times.

The Pharmacare program operates five plans.

- *Plan A* provides partial coverage to residents of BC, living in the community, who are 65 years of age or more. Over 338,000 seniors, or 90 percent of seniors living outside of institutions, received at least one prescription drug in 1989. On average, they received 12 prescriptions each at a cost of $53 to themselves and $331 to Pharmacare. Plan A accounts for approximately 58 percent of the total costs of the Pharmacare plans.
- *Plan B* provides complete coverage to residents of BC who reside in a licensed personal, or intermediate *long term care facility or private hospital. Virtually all of the 20,000 eligible residents receive at least one prescription drug per year. On average, they receive 40 prescriptions each at a cost to Pharmacare of $640 per person accounting for approximately 9 percent of the total costs of the Pharmacare plans. Residents of *extended care units are covered under Hospital Programs.
- *Plan C* provides complete coverage to residents, refugees and their dependents declared eligible for coverage by the Ministry of Social Services and Housing.
- *Plan E* provides partial coverage to all residents of BC who are not covered by Plans A, B or C or by a private prepaid prescription plan. Almost 70,000 individuals or families covered under this plan had prescription drug requirements which cost more than $375 each. On average, each claimant received 25 prescriptions at a cost of $431 to the claimant and $424 to Pharmacare. Plan E accounts for approximately 15 percent of the total costs of the Pharmacare plans.
- *Plan F* provides complete coverage to children who receive premium-free Medical Services Plan coverage through the *At Home Program*.

The *Home Oxygen Subsidy Program* provides assistance with the cost of oxygen for in-home use. Pharmacare provides coverage for the level of oxygen deemed necessary and rental of the concentrator and transtracheal supplies. Equipment such as masks and tubing are not covered.

The prescription drug requirements of seniors living on their own or in *intermediate care facilities (Plan A + Plan B) now account for almost 70 percent of the costs of Pharmacare. This has raised concerns about the cost implications of an aging population, but the effects are not just future effects.

The costs of Pharmacare programs over the last ten years have increased in relation to the percentage increase of elderly in the population. However, the percentage of the population that is 80 years of age and older is increasing at a much faster rate than that of the elderly population as a whole, and their numbers will double within the next ten years. Unfortunately, Pharmacare has not monitored prescription drug use by this segment of the population, making it difficult to predict future costs.

Drug Therapy

There is risk associated with the use of drugs and a significant number of admissions to hospital are a result of problems related to drug therapy. The College of Pharmacists of BC points out that one half of these admissions for the elderly are due to problems that could have been prevented: errors in prescribing, dispensing or taking the drug.

Inappropriate drug use, with resulting illness and death, is one of the five most important quality of care issues for the elderly. According to Dr. Lowy, chairman of the Pharmaceutical Inquiry of Ontario, the two biggest causes of this inappropriate drug use are:

- inadequate medical education
- testing and marketing activities of pharmaceutical companies.

Other reasons for a patient's receiving improper drugs, whether the patient is a senior or a member of the general population, include:

- the physician's lack of knowledge about drug therapy and discomfort with suggesting alternative therapy or no active therapy
- poor communications among the physician, patient and pharmacist
- a mistake in following the physician's order
- a general shortage of information about the effects of drugs, particularly on the elderly.

The Drug Usage Review (DUR) program at St. Paul's hospital was introduced in 1978 to compare existing prescribing patterns to pre-determined standards. A professional review committee, coordinated by the Faculty of Pharmaceutical Sciences of the University of British Columbia, funded by the Pharmacare program, and composed of representatives from the colleges and associations of medicine and pharmacy and the Registered Nurses Association of BC, determines these standards.

Because of limited resources, the committee targets a few drugs each year based on knowledge of drugs which have a high potential for misuse and, to a lesser extent, those which represent a high cost to the Pharmacare program. Using the Pharmacare database, trends can be identified by individual drug, drug group, region, medical specialty, practice type, and individual practitioner. However, the criteria used in selecting the target drugs are not well defined.

The DUR program uses two main strategies to bring practice in line with standards:

- distributing guidelines and standards for the prescribing of target drugs to every practitioner in the province
- identifying individual physicians and pharmacists with exceptional drug prescribing and dispensing patterns in relation to their peers, then using the college as an intermediary in investigating and solving identified problems.

The DUR program reports that internal evaluations of the effect of publishing the guidelines show a reduction in exceptional drug use of 15 to 50 percent. This reduction lasts for three months to two years.

As the number of available drugs increases, it is more and more difficult for physicians to stay up-to-date as to their proper use and effectiveness. Because of the complexity and cost of some pharmaceuticals, and the possibility of their being misused, the commission believes that certain drugs should only be prescribed by those specialists with the expertise necessary to understand their appropriate use.

Research indicates that 40% of all over-the-counter drugs and 36% of all prescription drugs are purchased by the elderly, yet the elderly make up only 12% of the total population.
HCP-018

Therefore, the commission recommends that:

1. **Pharmacare expand the responsibilities of the Drug Usage Review program to include**
   a. **developing criteria to select target drugs, expanding their number and determining whether certain drugs should only be prescribed by certain specialists; and**
   b. **ensuring individual compliance with Drug Usage Review guidelines.**
2. **the College of Physicians and Surgeons and College of Pharmacists assist the Drug Usage Review program in enforcing its guidelines.**
3. **Pharmacare foster the development of an electronic network linking all physicians, pharmacies, hospitals and intermediate care facilities so that physicians and pharmacists have access to**
   a. **the diagnosis, medication profile and allergy status of a patient;**
   b. **information regarding potential drug/drug and drug/disease interactions;**
   c. **prescribing guidelines compiled by the Drug Usage Review program; and**
   d. **information available through the Drug and Poison Information Centre.**

The commission recognizes that confidentiality and privacy are significant concerns and must be maintained to the extent possible.

4. **the UBC Faculty of Pharmaceutical Sciences continue to emphasize the pharmacological needs of the elderly.**
5. **the College of Pharmacists emphasize the medication needs of the elderly in testing and continuing education.**

According to the BC Branch of the Canadian Society of Hospital Pharmacists, there is a good chance that, at some point during the day, a patient in a hospital bed in BC will receive either the wrong drug or the wrong dose. The error may be the misjudgment of the physician, or it may be that the hospital staff did not follow the physician's orders or the policies and procedures of the hospital. The Hospital Pharmacists also point out that there is a particular risk of medication errors in rural hospitals with fewer than 100 beds, as more than 40 of these hospitals do not employ on-site pharmacists.

This error rate could be decreased by the use of a *unit dose system, a *modified unit dose system, or an *intravenous (IV) admixture system. These systems might also save the hospital money through the more efficient use of nurses, more effective inventory control, or the bulk purchase of IV drugs. The Hospital Programs Division of the Ministry, the BC Health Association, the College of Pharmacists of BC and the Canadian Society of Hospital Pharmacists (BC Branch) should study the effectiveness of such systems in hospitals of varying sizes.

Therefore, the commission recommends that:

6. **hospitals of sufficient size reallocate funding to implement unit dose or IV admixture systems.**
7. **the Hospital Programs Division ensure that all hospitals provide an appropriate standard of pharmaceutical services which might include an electronic link to a regional centre, or a link to the Drug Usage Review program.**

We believe that pharmacists have extensive knowledge to share with physicians and expect that an active clinical role by pharmacists will improve the quality of drug care within hospitals. Hospital management should ensure that the clinical role of pharmacists results in more appropriate drug therapy.

Therefore, the commission recommends that:

8. **pharmacists play an active clinical role in hospital and ward rounds.**

The effects of prescription drugs are not properly evaluated. The elderly, children, pregnant women and patients with multiple illnesses are not included in the clinical trials required to approve the sale of a drug product, and surveillance of the product ends once it is approved. Post-marketing surveillance needs to be carried out on pharmaceuticals. One method might be to coordinate surveillance through the present World Health Organization's *Monitoring and Assessment of Adverse Drug Effects*.

Therefore, the commission recommends that:

9. **the provincial government urge the federal minister of health to**
   a. **grant conditional approval for the sale of new drugs after Phase III trials. Final approval shall depend on the satisfactory completion of post-marketing surveillance which includes evaluation of the effects on population groups excluded from Phase III trials; and**
   b. **take an active role in collaborating with other countries in the post-marketing surveillance of prescription drugs.**

Even when patients are dispensed the proper drug, more than half of them take their prescriptions incorrectly. This may occur because patients:

- do not have the right instructions from their physicians, pharmacists or caregivers
- do not understand the instructions they are given or have difficulty reading
- do not remember which medications they have taken
- have difficulty opening the medication container.

The pharmacist is often an underutilized resource, not only in proper medication management, but in overall cost containment.
SUP-024

One Canadian study found that 5 percent of hospital admissions were due to patients deliberately taking prescriptions incorrectly. This may occur because a patient:

- does not believe the recommended dose is needed
- does not like the medication's side effects
- wants more relief or effect
- wants to try a drug prescribed for another problem or another person.

The commissioners also heard that millions of dollars are wasted in unused medications; up to 50 percent of dispensed drugs may be only partially used. Pharmacare and the BC Pharmacy Association recently developed a pilot project to reduce this waste. In this Trial Prescription Program, pharmacists dispensed medications in small amounts for expensive drugs which were known to have bad side effects for some patients. Pharmacare paid the complete dispensing fee for the trial amount and, if the patient suffered no ill effects, the balance of the prescription was dispensed and paid for as usual. If the patient suffered from the side effects, the pharmacist and physician were aware of the problem and the balance of the prescription was not dispersed. Although the pilot did not achieve the maximum savings possible, almost one-third of the prescriptions were discontinued, and the cost of the additional dispensing fees was considerably less than the savings in unused drugs.

Some pharmacies use individual compartment returnable packages to help elderly people follow the dosage directions. Others use large print for instructions. At best, the incorrect use of prescription drugs compromises the therapeutic effects of the drug; at worst, the patient gets sicker or dies.

Therefore, the commission recommends that:

10. the provincial government urge the federal Health Protection Directorate to require drug manufacturers to package products in inexpensive ways that assist patients in taking their drugs correctly.

11. Pharmacare

   a. pay pharmacists for the cost of dispensing drugs in returnable packages or containers to patients who require assistance in taking their drugs correctly; and

   b. implement the Trial Prescription Program for selected drugs, and educate physicians, pharmacists, and their respective colleges about the objectives of the program.

The Seniors Drug Action Program (SDAP) was allocated funds for a three year term from 1988/89 to 1990/91 through the Prevention and Treatment of Substance Abuse Vote of the Ministry of Labour and Consumer Services. The objectives of the program are to promote rational drug prescribing and to foster the informed use of drugs for the benefit of senior citizens in the province. The program tries to achieve these objectives through 15 projects for the elderly and health care workers which include the distribution of fact sheets, guidelines and instructional modules, and the provision of advice, consultation and drug use review at the community level. SDAP's advisory committee includes nurses, physicians, pharmacists, *homemakers and representatives from intermediate care and other health facilities, and from the UBC faculties of medicine and pharmaceutical sciences.

SDAP is seeking permanent funding through the Pharmacare program of the Medical Services Commission. It is basing its application on an external evaluation of the program and an internal evaluation of the projects. The external evaluation found the program to be well organized and administered, and the component projects and strategies well conceived and implemented. But the evaluation did not measure behavioural change, such as increased compliance, decreased use of unnecessary drugs, or improved physician prescribing patterns, to determine the effectiveness of the program. The commission believes that SDAP has the potential to help people take the proper drugs at the proper dosage and at the proper time, but SDAP must evaluate the outcomes of its activities and offer only those which have a positive effect. Being well organized is important, but it is only the first step.

We are also concerned that the present provincial requirement for packaging medications in child-proof containers excludes medications for which no child-proof cap has been designed. Most liquid medications, including liquid antibiotics, are dispensed in bottles without child-proof caps.

Therefore, the commission recommends that:

12. the provincial government urge the Health Protection Directorate to require that all medications be packaged in child-proof containers.

Access to Prescription Drugs

The province provides excellent coverage for prescription drug therapy for all BC residents. The Pharmacare program pays for the complete prescription drug costs of the poor, residents of intermediate care facilities, and severely disabled children living at home. All those remaining, including seniors, are only responsible for a portion of their drug costs.

Seniors (65 years and over) must pay 75 percent of the dispensing fee until they have paid a maximum of $125 per person annually. People under 65 years of age pay their complete drug costs up to $325 per family and then pay 20 percent of their total prescription cost until the family has paid a maximum of $2000 annually. Generally, people do not have a problem paying the deductible amount, but some who have paid the deductible may have difficulty paying for complete drug costs and waiting for reimbursement.

Therefore, the commission recommends that:

13. Pharmacare ensure that the electronic network enables pharmacists to determine the amount patients have paid toward their deductible, and that a system be devised whereby patients only pay their portion of the deductible.

The commission is also concerned about the working poor's lack of access to prescription drugs. Families who do not receive social assistance are responsible for an annual amount of up to $2000. This is a large amount of money for lower income families with medication requirements for chronic conditions and, therefore, large prescription drug requirements. At the same time, people with a substantial income could pay more.

There are some low income families who do not benefit from the method of reimbursement now in place for prescription drugs, because they cannot afford to pay for the drugs in the first place.
UNI-027

Therefore, the commission recommends that:

14. the deductable portion for Plan E be changed from a flat $2,000 to five percent of a family's income, to be administered, if practicable, through the taxation system.

The Lowest Possible Cost

While the proportion of hospital budgets devoted to drug therapy remains fairly stable, Pharmacare is consuming an increasing portion of the health care dollar.

Two components make up the cost of a prescription: the cost of the drug and the dispensing fee, which is the amount paid to the pharmacist for all administrative and overhead costs. The cost of the drug is most responsible for the rising cost of prescriptions, increasing at an annual rate of almost 14 percent over the rate of inflation. The dispensing fee is actually increasing at a rate slower than that of inflation.

The actual prescribing practices of physicians are heavily influenced by drug companies, and the pharmaceutical industry may well be the primary source of continuing education for many physicians.
PRO-007

AVERAGE ANNUAL INCREASE IN COSTS IN ADDITION TO INFLATION BETWEEN 1985 AND 1989

Ministry of Health	4.5%
Pharmacare	6.7%
Pharmacare & Claimant*	9.3%
Dispensing Fee	-1.3%
Drug Cost	13.7%

Note: * Based on information for Pharmacare plans A, B, and C as details of Plans E and F not available

Because the drug cost usually represents more than 70 percent of the prescription cost, Pharmacare may save millions of dollars by controlling these costs. For example, a 15 percent increase in the drug component cost of seniors Plan A from 1989 to 1990 resulted in an increased cost to Pharmacare of approximately $16 million.

Clamping down on the rise in drug costs is a formidable task. It will include not only better use and prescribing, but also buying drugs at lowest possible unit cost. Pharmaceutical companies are well-entrenched international businesses with high profit margins. According to the Pharmaceutical Inquiry of Ontario, profit after tax on equity is almost 25 percent compared with a manufacturing industry average of less than 11 percent. Of the money devoted to research and development, only 20-30 percent is spent on new products, 25-30 percent is spent on new dosage forms or new uses of existing products, and half of all research and development money is spent on copying other products.

The vast majority of pharmaceutical research and development in Canada is concentrated in Ontario and Quebec. According to the Pharmaceutical Manufacturing Association of Canada, only $8.22 million, three percent of the total $244 million spent on research and development in Canada, was spent in BC. The federal government provides the initial means of keeping drug costs at a reasonable level. With the introduction of amendments to the federal Patent Act in December, 1987, drug manufacturers are assured of a seven to ten year patent on their products. The only way to control excessive pricing is to ensure that the federal Patented Medicine Prices Review Board sets a reasonable price. If it does not do its work well, a significant portion of the additional cost will be borne by the provincial Pharmacare program.

Once a drug product is offered for sale in Canada, the province may stem rising costs by:

- increasing the substitution of lower priced generic products
- reducing the amount of drugs that are dispensed but never used
- allowing competitive sales for those products which do not require counselling and monitoring by the pharmacist.

Therefore, the commission recommends that:

15. provincial ministers of health periodically monitor the financial effectiveness of the Patented Medicine Prices Review Board, and make that review public.

Physicians and pharmacists in BC do not take full advantage of lower-priced drug products. Physicians may not prescribe generic products, because the cost of drugs is irrelevant to their practice or they lack knowledge about the cost and effectiveness of alternative drug products. While a physician usually speaks to a pharmacist only once every six months, physicians hear the sales pitches of representatives of pharmaceutical manufacturing companies once every two weeks.

A recent study comparing the ability of the Ontario and BC drug plans to control expenditures on high-volume interchangeable drug products found that, although the prices of high and low priced brands are similar in BC and Ontario, the lower-priced brands have a much greater market share in Ontario. Because Ontario pays pharmacists for the cost of the lowest-priced drug product in each interchangeable class, lower-priced brands of the high volume classes claim 85 percent of the Ontario market on average. In BC, lower-priced brands in these same high volume classes claim only 35 percent of the market.

A good example of how the province could save money by increasing the use of alternative products is the use of the brand name drug Zantac and its substitute generic products. In 1989, seniors living at home received $2.8 million worth of Zantac and $2.5 million of generic products. Although 150 mg tablets of Zantac cost 95 cents a pill and the lowest priced equivalent product cost only 64 cents a pill, Zantac was dispensed 44 percent of the time. If the lowest priced product were substituted for Zantac, Pharmacare and seniors would save almost $1 million a year. It must be noted, though, that Zantac has the highest total drug cost of all drug classes for seniors and that this type of savings does not apply across the board. About a third of the top 150 drug products paid for by Pharmacare do not have generic equivalents.

The province could encourage physicians to use generic products through education, financial incentives, or regulation. Ontario has a set of pricing and product selection rules designed to capture the lowest possible price. The Ontario Ministry of Health gets information on the best available price for drug products in different package sizes from both wholesale and retail sources and develops a list detailing the best available price. If the drug has only one source, the pharmacist will dispense that brand and be paid for the list price. If the drug is produced by more than one manufacturer (i.e., both brand name and generic) the pharmacist will be paid for the price of the lowest priced product regardless of the product dispensed.

Pharmacare has recently implemented the Product Incentive Program to provide a financial incentive to pharmacists. Pharmacare and the BC Pharmacists' Association developed product classes of drugs consisting of a brand name product and the equivalent generic products. A base price was then set 10 percent higher than the average provincial price of the most expensive drug in each product class. The plan then pays pharmacists 20 percent of the difference between the generic drug they dispense and this base price.

We have been told that a negative side effect of this plan might be to encourage manufacturers of generic products to increase prices to the base level. The Product Incentive Program is so new, though, that it is impossible to judge its results or effectiveness.

Therefore, the commission recommends that:

16. the Ministry of Health
  a. implement a system of mandatory drug price and product selection; and
  b. encourage the Health Protection Directorate to establish one such list for the nation.

17. Pharmacare
  a. develop a list of drug products which are covered by the Plans;
  b develop a list of drug products and their equivalents for selected drugs;
  c. provide the preceding lists of drug products and their prices through the electronic network once it is in operation;
  d. request bids from drug manufacturers for providing selected drug products to pharmacists throughout the province;
  e. only pay the pharmacist for the lowest priced equivalent drug product unless the physician prescribing a more expensive product has written 'do not substitute' on the prescription and has detailed the patients' need for this particular product; and
  f. monitor the prescribing decisions of those physicians who write 'do not substitute' prescriptions significantly more often than their peers.

The commission suggests that, due to the complicated relationships of drug prices, dispensing fees, the demand for prescription drugs and the overall costs to the province, Pharmacare should continually monitor the effect of its payment policies, and change these policies as necessary to provide incentives to pharmacists and physicians. An example of a situation that requires monitoring is the listing of eligible *single source drug products. Products that are *modified release dosage forms are listed as single source because they differ in chemical composition from other drugs, but they may have the same therapeutic effect as other drug products. Pharmacare may wish to pay for the lowest priced product which has the equivalent effect.

The commission is also concerned about the number of non-prescription drug products for which prescriptions are written, or which may only be sold within 25 feet of a pharmacist. If a drug product does not require a prescription and does not contain controlled substances, it should be available for sale by retail stores.

We're bombarded
by costly medications.
SOC-116

Therefore, the commission recommends that:

18. the province
  a. prohibit the filling of prescriptions for drugs that are available on the open shelf; and
  b. limit the number of drug products which must be sold within 25 feet of a pharmacist to those containing controlled substances.

19. the pharmacist be directly involved in dispensing those drug products which require the supervision of a pharmacist.

* GLOSSARY

HOSPITALS

A number of *submissions to the commission emphasized that, wherever possible, care in one's own home is preferable to care in an institution. When that is not possible, care in one's own community, and in as homelike an atmosphere as possible, is preferable to care in a hospital. This implies an expansion in *home care programs and other outpatient care, as well as an increase in *intermediate care and other residential facilities as alternatives to hospitalization.

The commission agrees that care in one's own home is preferable to institutional care and we have adopted "Closer to Home" as a principle with which to guide changes in the health care system.

However, we think that it is unlikely that there will be substantial amounts of additional funding available, now or in the foreseeable future, for health care in BC. If alternative programs are going to be implemented, the resources must be found within the present budget. If these programs are not truly alternatives to existing programs, but merely add-ons, then the pressures on the health care system could become unbearable.

Therefore, the appropriateness of *acute care hospital use and the proper scale and scope of the hospital sector are the most significant questions to be addressed under the general heading of ***Hospitals***. They are by no means the only important hospital issues raised in submissions to the commission, but they are the central issues. Because of its importance to the future of health care in BC, we strongly recommend that the reader take this opportunity to study the text and recommendations contained in ***Careful Spending*** before proceeding with this chapter.

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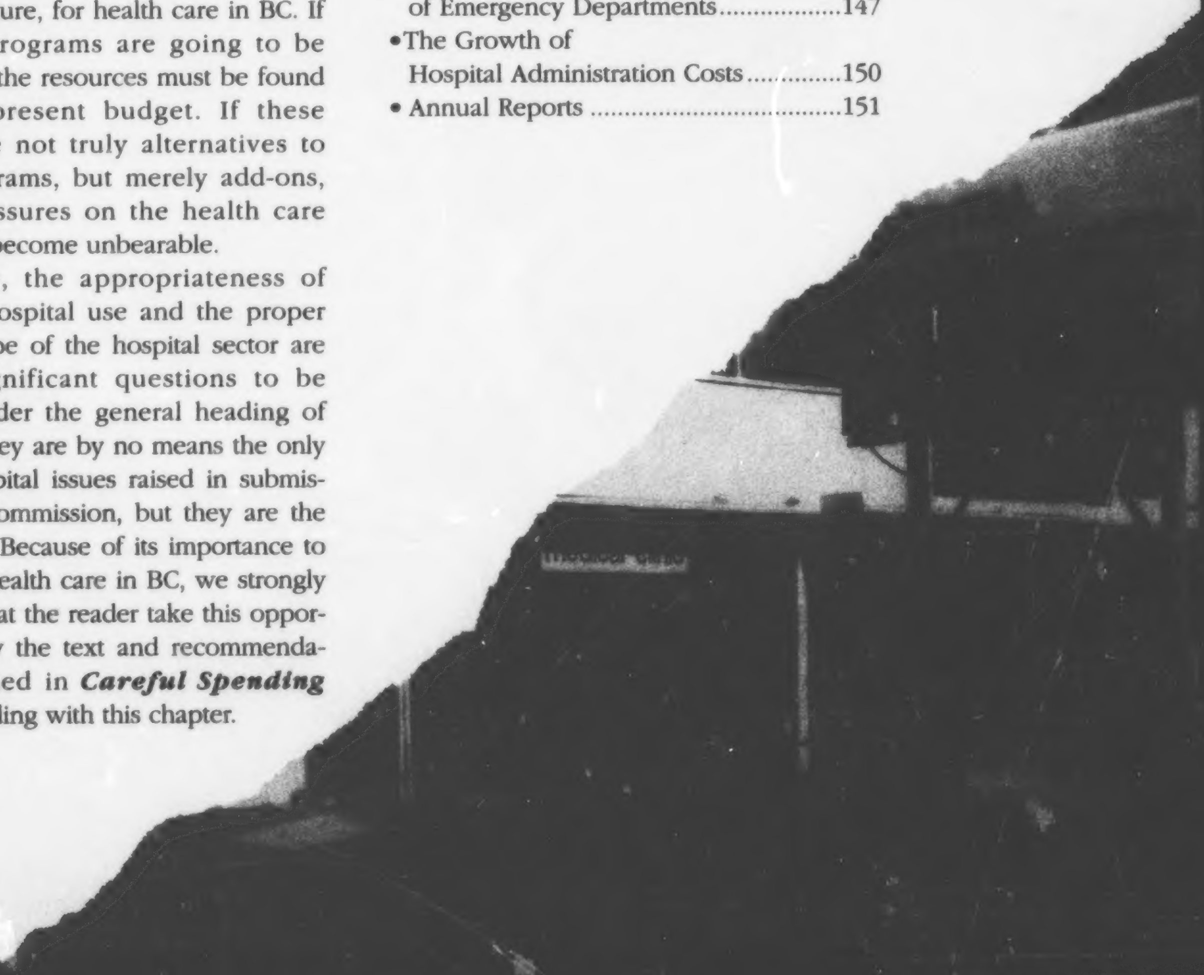

Hospital Costs and Expenditure in BC

Relative to the rest of Canada, BC's hospital system is not excessively costly. Data compiled by Health and Welfare Canada indicate that, except for the early 1980s, per capita expenditure on hospitals in BC has consistently been below the national average. Such expenditure has increased more rapidly than the general price level, but less rapidly than in the rest of the country. Relative to our Provincial Gross Domestic Product, an indicator of our overall ability to pay, BC has been below the national average by about ten percent or more for at least the last two decades.

But this is only true for hospitals. Total health care spending in BC takes up virtually the same share of income and output as it does in the rest of Canada. The difference is that we spend substantially more on physicians.

From these data alone, then, one might conclude – as do some submissions – that BC hospitals are underfunded and that if any part of the health care budget needs shrinking, it should be payments for physicians' services. The most important question, though, is whether the care provided by the money being spent is adequate to meet the needs of the people of the province. Expenditure data, by themselves, shed very little light on this question.

A true health care system would concentrate on reducing our need for doctors and nurses in acute care hospitals. Obviously there will always be a need but our objective should be the reduction of that need.
MUN-020

•Interprovincial Comparisons of Hospital Use

In the mid-1980s, British Columbians spent almost exactly the same amount of time in hospital beds as other Canadians – about 2,100 days for each 1,000 people, or just over two days per person each year. Therefore, lower levels of hospital spending did not translate into lower rates of use.

This is because a higher proportion of patient time in BC was spent in *extended care beds, either in long term wards of acute care hospitals or in extended care hospitals. As a result, the average costs for each patient day in BC were lower than in the rest of Canada in the mid-1980s because they included a higher proportion of less expensive extended care patient days. This suggests that hospitals in BC have already gone farther in substituting less intensive facilities for acute care beds than hospitals in the rest of the country.

It is important to note, however, that while there are similarities among provinces in the overall rates of institutionalization, the level at which people are cared for varies widely for no apparent reason. The Canadian average represents a statistical grouping, not a standard of appropriate care.

The above-average use of extended care beds in BC, particularly in long term wards or annexes attached to acute care hospitals, raises two questions:

- Could more effective use of home care and various forms of non-hospital residential facilities reduce the need for extended care beds?
- Has the development of extended care beds in conjunction with acute care hospitals led to an over-medicalization of patients and an inappropriate level of diagnostic intervention?

We believe the answer to both questions is "Yes". But we want to put our position with some care.

We are concerned that the independence of very elderly people is extremely fragile, and that long periods of *inpatient care can lead to their losing control of their lives and becoming permanently institutionalized. Thus, keeping people out of institutions is not just a way of saving money; it is an important way of protecting health and avoiding or deferring the loss of independence.

Moreover, as explained in ***Careful Spending***, we think that a substantial number of people occupying acute care beds should be in some form of *continuing care.

There is evidence, however, that the rapid growth of extended care within or alongside acute care hospitals in BC has been associated with an increasing designation of the problems of the elderly in medical terms, and with a level of intervention which may be inappropriate. People in such facilities undergo procedures at a much higher rate than patients in independent extended care hospitals. Obviously they must be properly assessed, but, for many people in these facilities, aggressive or routine interventions may be as inappropriate as they would be in a private home.

We know that with the aging of the population, there will be a greater need for *long term care beds for the frail elderly in BC. Some of these beds should be in extended care. But extended care facilities should be administratively and culturally separated from acute care hospitals. They should be comfortable places in which to live, organized and regarded as if they were the residents' homes, rather than convenient places to provide diagnosis and therapy.

Studies tend to focus on variations in regional inpatient use because comprehensive data collected over long periods of time are available on them. But, unlike most other jurisdictions, BC also has detailed data on day care surgical procedures.

The substitution of day care procedures for inpatient care is not a new idea. It goes back to the mid-1960s and, in fact, clinicians in BC were among its North American pioneers, advocating it for reasons of quality as often as, or more than, for cost savings. Yet 20 years later, the striking regional variations found in the day care data indicate that the application of this form of care remains quite uneven across the province. In the absence of differences in the needs of the people treated, or in health *outcomes, these variations once again suggest that there are opportunities for further reducing inpatient use.

According to one analysis carried out for the commission, British Columbians could have saved approximately 680,000 acute and rehabilitation inpatient days, out of a total of 3.2 million days in fiscal year 1989/90, by shortening average lengths of stay. About 30,000 inpatient stays could have been eliminated entirely. These potentially avoidable patient days were spread across all diagnostic categories and were found in all of the hospitals which were examined. Six hundred and eighty thousand days represent the capacity of over 2,300 beds run at 80 percent occupancy. These numbers are enormous and represent a potential pool of funds that should be redirected toward more appropriate and efficient care.

Our study of individual hospitals also highlighted the fact that patients who were similar, at least according to the data on their separation records (discharges and deaths), had very different stays in different hospitals. These were differences in averages across all such patients in each hospital, and were not the results of a single, unusual individual.

Although excess days were found in all diagnostic categories, about half the days could have been saved by reducing the length of stay in only four categories: neoplasms, injury and poisoning, circulatory diseases and complications of pregnancy. This means that it is possible to have a significant effect on overall hospital use by initially focusing on only a few patterns of care. ***We do not need to try to solve everything at once.***

For example, in obstetrics, the missed opportunities for early maternal discharge and the inappropriately high rates of caesarean section in Canada are already well known. Less well known, though, is the fact that, in BC at least, the proportion of deliveries labelled normal on discharge has been declining steadily for a number of years and is now only a small fraction of all births. From this it would appear that physicians' perceptions of complications, or at least their labelling behaviour, have shifted significantly over the last decade.

Because our estimate of 680,000 excess acute care days includes a high proportion of short-stay patients who stayed longer than necessary, we also carried out an analysis which focused specifically on long-stay patients occupying acute care beds. Several submissions identified this group as using an inappropriate number of acute care bed days. They are sometimes referred to as "bed blockers," an unfortunate term.

There is no specific count of long term care patients inappropriately occupying acute care beds. Instead, we gathered data on total bed days which accounted for three different types of discharges during the fiscal years 1984/85 and 1988/89.

- Patients with a discharge diagnosis indicating that the majority of days during the episode were while "awaiting placement."
- Patients who, in the course of their stay, were assessed as eligible for placement in long term care, but for whom no facility was available.
- Patients with a length of stay of 30 days or more, but meeting neither of the first two criteria. The first 29 days were not counted as long term care days for patients in this category.

Using these three definitions, long-stay patients in acute care beds accounted for more than 700,000 inpatient days in both 1984/85 and 1988/89, or over 20 percent of all days in inpatient beds. Over the four-year period, however, the third group fell from about 70 percent of the total of the three groups to about 60 percent, while the other two groups increased their share. This suggests an increasing recognition of the inappropriateness of long stays in acute care beds, though little change in the scale of the problem.

The findings of these two studies appear quite similar – 680,000 excess acute care bed days and 700,000 inpatient days accounted for by long term patients in acute care beds – but there is an important difference. The first study excluded patients assessed for continuing care and waiting placement, and focused on the 3.2 million patient days used by acute care patients. The second study included these patients, adding approximately a quarter-million savable patient days, but it excluded potentially avoidable patient days. The total savable days indicated by these two studies taken together is therefore much greater than that found in either of them separately. The difference may be as much as 100,000-200,000 bed days.

The study of long-stay patients also determined that there were about 21,000 *hospital separations which fell into one of the three categories listed above. This is less than 5 percent of the 450,000 separations in the year. Comparisons across four years indicate that these numbers were quite stable over that period of time.

It is on the basis of this information that the commission has recommended the reduction of per capita, age adjusted acute care bed use by 25 percent in the next five years, a reduction in acute care beds per capita, and an expansion of alternative forms of care. All of these recommendations are contained in ***Careful Spending***. However, it is important to note here that these recommendations do not fly in the face of projections which show an aging population needing increased hospital care. Our recommendations apply to per capita, age adjusted acute care use. A 25 percent reduction will result in reducing total inpatient days by only 10-15 percent over five years.

It is also important to note that most of the increase in hospital use by the elderly during the last two decades has not occurred because there are so many more elderly people, but because elderly people are, on average, spending more time in hospitals. For example, surgical procedures for elderly patients have increased in frequency. This has been associated with recent improvements in the technology underlying certain procedures – particularly lens implants, joint replacements, and certain cardiac procedures – as well as in the skill and experience of surgeons. Such surgery can now be expected to benefit many more patients. However, there is a great deal of controversy about the magnitude of the increases in performing these procedures. There is also a very real concern about the growing number of interventions involving the frail elderly for whom the expectation of benefit may be too small to justify the trauma of surgery.

A considerable proportion of the increased use of hospitals by the elderly is precisely the long stays in acute care beds which have been identified as inappropriate. If these stays could be shortened or eliminated, the projected effect of an aging population on our health care system would be much smaller. Building more acute care beds to house an increasing elderly population is therefore what we do not want to do.

Worldwide developments in medical science and technology interact with the special characteristics of the local environment to produce the trends which we observe here. The concerns which we have raised – the appropriateness of particular surgical interventions for the elderly population, the medicalization of long term care, the need to shift care closer to home — are also topics of concern internationally and are not the consequence of local characteristics or the funding of the Canadian health care system.

In our view, the extended care sector will be larger in the future health care system but, as stated in ***Long Term Care*** and ***Home Care,*** a greater emphasis must be placed on its residential nature and less on diagnosis and therapy than occurs now. The whole range of less intensive programs and facilities will also be expanded, including various forms of congregate residential facilities in which residents can continue to maintain a degree of independence, and *multi-level facilities where residents move to progressively greater degrees of assistance – medical and non-medical – as necessary. Specific reductions in acute care bed capacity and use are central to the transfer of people and resources out of acute care to more appropriate settings, and the resources to fund these changes will come from the acute care sector as the present excessive levels of use are reduced. But the objective must be better care, closer to home, not simply the exchange of one institutional bed for another.

We are not asking
for a whole lot more
acute care beds,
realizing that we are
just not going
to need them.
But extended care beds,
we have
a defined need for.
HOS-129

* GLOSSARY

Therefore, the commission recommends that:

1. **the Ministry of Health**
   1. **increase home support programs in order to shift both resources and patients out of the institutional setting;**
   2. **expand outpatient and community health services through program budgeting;**
   3. **require all acute care hospitals to establish standards for *utilization management, and ensure compliance with these standards;**
   4. **preferentially expand non-hospital multi-level nursing homes, independent of hospitals, able to provide extended and intermediate care, and provide other residential facilities; and**
   5. **evaluate the effectiveness of the hospital/community partnership program, as a whole and with respect to its specific component programs, to determine if it is in fact shifting resources out of the inpatient setting. The continuation or expansion of these programs shall depend on their demonstrated effectiveness in achieving this objective.**

Hospital Funding Formulas

There are a number of long-standing complaints about hospitals being funded through global budgets negotiated annually between each hospital and the Ministry of Health. This system is said to be unsatisfactory and unfair because:

- annual budgets tend to be built up by proportionate adjustments to the previous year giving a fat (lean) hospital a permanent advantage (disadvantage)
- the funding system penalizes managerial efficiency by reducing the base budgets of hospitals which successfully limit their growth
- an innovative administration which shifts patients from inpatient to ambulatory or home care is likely to get into budgetary difficulty as the provincial government may not fully recognize the increased costliness of the remaining, more severely ill patients
- freed-up inpatient capacity leads physicians to admit more patients, causing the total costs of the institution to rise, and deficits to follow.

These are familiar complaints. Their persistence indicates that no perfect system for funding hospitals has been developed and improvements to the funding system will not be easily found. However, the commission thinks that the recently introduced formula for allocating additional funds from Hospital Programs is moving in the right direction. This population-based formula does have certain flaws, but it appears to be flexible enough to compensate for them.

Under this formula, new money is not distributed directly to hospitals. Instead, ministry staff first estimate the change in population size and structure for each region of the province (*local health area).

They then calculate the amount by which that region's use of hospital care, measured in *weighted patient days (WPDs), would increase if each new member of the region's population used care at exactly the same rate as the provincial average for people of the same age and sex.

This calculation gives the expected increase in hospital workload required to provide care for the expected increase in each region's population. The expected increase is then divided among the hospitals which serve that region's population, whether or not the hospitals providing the services are actually located in the region. For example, if three-quarters of the WPDs used by the people in one of BC's Local Health Areas were provided in a local hospital, and one-quarter were provided in a hospital outside of the region, then the expected increase in workload is divided between these hospitals in the proportions 3/4:1/4.

Ministry staff then adjust the formula by the actual cost of care in each hospital. For example, if the cost of each WPD of service provided in the hospital outside of the region were twice as large as the cost in the local hospital – perhaps because it is a *tertiary care hospital – the external hospital's one-quarter share would be given a double weight, two shares out of five. It would, therefore, be allocated two-fifths, not one-quarter, of the cost-weighted expected increase in regional workload. This cost adjustment recognizes that patients referred out to higher-cost hospitals are, on average, the more severely ill.

In the final step, the cost–weighted expected increases in regional workloads are added together to reach a provincial total. This total is then compared with the amount of additional money Hospital Programs has actually budgeted for acute care hospitals in the year. The additional money is then divided among the hospitals in proportion to their share of the total expected increase in cost-weighted workload.

The fundamental principle embodied in this process is that resources should be allocated to care for people, not to support institutions. The money allocated to care for a population should follow those people to wherever they receive their care. This principle is part of the general thrust of this report and is embodied in our recommendations on capitated, population-based regional budgets, discussed in ***The Management of Health Care Services***. Adjusted to provide a proportion of hospital funding as a base to support *fixed costs*, which do not vary with the workload, this formula should apply to the whole of the hospital budget, and not just to new money.

It is widely recognized that in a capitated funding system, age and sex are incomplete indicators of the health care needs of a population. The commission has been told that the ministry is currently working to identify and incorporate other characteristics of regional populations into the funding formula. These might include income, education, employment status, the degree of remoteness and specific measures of ill health. These characteristics will also be very important for establishing the regional health care funding envelopes discussed in ***The Management of Health Care Services***.

Financial planning takes place in an informational vacuum which causes stress and concern at all levels of hospital operation.
HOS-099

* GLOSSARY

All such efforts are, however, limited by the fact that population characteristics are based on regional averages and do not necessarily apply to individuals. Over the long term, we will need data bases that are person-specific as well as population-based, in order to understand more completely the relationship between population characteristics and health care needs, and therefore to allocate health care funds more fairly. Regional variations in health status cannot all be remedied by any one form of health care intervention, and a population with poor health status may benefit very little, if at all, from more hospital funding. More support for non-hospital based health care, allocated according to the priorities of the people in that region, may be much more effective.

A further principle which should be included in allocating health care resources is that people and institutions should be paid for performance. In simple terms, care providers should be paid for doing things, and not for not doing them. But this idea is too simple. What we mean is that they should only be paid for doing the right things, improving someone's health, and not for doing the wrong ones. In some circumstances, the best possible thing to do may be nothing. Embodying these ideas in a funding formula is not easy. The present one has several weaknesses in this regard.

For example, since the regional allocation of expected workload is currently based upon provincial averages, a population which has a pattern of low use relative to the rest of the province will be given resources beyond its current needs. If this pattern persists, hospitals serving that population are in effect being over paid. If the lower use is a consequence of careful utilization management and providing alternative services, then the payment is appropriate. However, the financial benefits to the hospitals are the same, even if the lower use rates result from unresponsiveness to patients' needs, limited access, or long waiting times.

Features of the funding formula would discourage deliberate or negligent underservicing, even if the formula were extended to cover all hospital funding in conjunction with regional envelopes. These are in addition to oversight by the ministry and the Board of Trustees as community representatives.

- If patients have difficulty gaining access to their regional hospitals, they may be referred elsewhere, bringing a share of the regional budget allocation from the hospitals with them.
- If regional health services become capitated, the local agencies responsible for allocating funds will be in a position to transfer funds away from "underserving" hospitals and to encourage the development of alternative facilities.

To encourage this latter step, the ministry should include the activities of free-standing clinics, which provide services similar to those provided in hospitals, in their measure of regional workloads. This would specifically expand the role of such facilities in the current system, a change which the commission has recommended in ***Careful Spending.***

For example, abortions are currently being provided both in hospitals and, to a much more limited degree, in free-standing clinics. The procedure is counted as a certain number of weighted patient days which become part of the hospital's workload if it is performed in a hospital. This workload, in turn, determines the hospital's share of funding from Hospital Programs. If the same procedure is performed in a free-standing clinic, that clinic should be credited with the equivalent workload and a corresponding share of

Hospital Programs' funds. In this way, a hospital which does not provide abortions would automatically lose the portion of its budgetary share equivalent to its reduced workload.

Therefore, the commission recommends that:

2. **a free-standing clinic or other institution which provides services equivalent to those of a hospital and for which a hospital would have received an allocation of weighted patient days, be assigned an allocation of weighted patient days as if it were a hospital, and thus receive a share of Hospital Programs funding equal to that which a hospital would have received for providing the same service to the same population.**

This recommendation is not, of course, restricted to abortions and we have chosen to discuss them simply because they are a well known example of a procedure available at a free-standing clinic. Indeed, this recommendation applies to any service which can be carried out equally well in a hospital or in a separate facility. By *service,* we mean an episode of care such as a day care surgical visit. We are not referring to any diagnostic or therapeutic procedure which might be provided as part of an episode of inpatient or *ambulatory care, but which would not normally be included as a separately identified component of a hospital's workload.

If underprovision is one horn of the dilemma of hospital funding, overprovision is the other. Under the present formula, a hospital can expand its share of resources – though not the total amount of resources available – by increasing its level of servicing. Its costs also increase, but perhaps not by as much. If, for example, a hospital's length of stay and occupancy rates are above the provincial average because it is relatively slow in discharging patients, then its workload and its share of the overall funds will rise. Since additional days of stay are relatively low cost, this strategy could improve the financial position of the hospital, while making the whole system less efficient. It could also reduce patient access, if admissions became more difficult. Again there are checks on this behaviour, but a funding formula should not contain improper financial incentives, and then rely on other mechanisms to offset them.

The formula has another problem. By adjusting each hospital's share of the regional workload by the cost of providing services in that hospital, the formula allocates more resources to the more expensive hospitals. If those hospitals are, in fact, doing more expensive work then the additional funding is appropriate. But the formula will also reward high costs that result from inefficiency and managerial incompetence. In this case, the hospital that spends more, gets more.

To deal with this situation, the ministry has begun to weight the share of regional workloads provided in each hospital by the average cost of services in a peer group of similar hospitals, rather than by the hospital's own cost experience. Hospitals will no longer be able to increase their budgetary shares by increasing their own costs per unit of workload, nor will they lose from increased efficiency. But this approach rests both on the validity of the peer groupings of hospitals – which are contentious – and on the assumption that the average for the group itself is appropriate.

Vancouver General Hospital has a budget of over a quarter of a billion dollars. And at the present time they have no accurate way of determining how the money is spent.
HCP-179

* GLOSSARY

Better information on the comparative costs of different procedures and services in different hospitals is obviously needed, for management purposes as well as for the funding formula. It is difficult to imagine how a large organization such as a hospital or health care system can be effectively managed without such information, but the commission has been told that such cost comparisons are not possible now. Better information systems are by no means a guarantee of improved management, but we believe they are a necessary condition for improvement.

Therefore, the commission recommends that:

3. **the Ministry of Health require all larger hospitals (e.g., those over 100 acute care beds) to use common accounting guidelines for determining costs, such that it is possible to compare the costs of the same procedure or activity in two or more hospitals.**

We understand that a detailed and sophisticated management information system framework for hospital accounting has been developed by Statistics Canada and the Canadian Hospital Association, which, if fully implemented, would permit each hospital to know, on the basis of a common set of detailed accounting conventions, what its costs were for every procedure performed or patient treated. But we have also been reminded in a number of submissions that information, like health care itself, should be subject to the test that its benefits exceed its costs. Therefore, we do not feel able to recommend any particular system of accounting. It must be possible, however, to develop approximate guidelines which will improve on the present situation.

A larger number of categories in which to classify hospital activities would lead to less variation within the categories, and less need for hospital-specific weighting. Therefore, a first step in improving accounting would be to develop a finer set of distinctions for the weighted patient days now used in the funding formula. At present, this measurement is based on only five sub-components: inpatient days in acute or rehabilitative care; days in a cardiac care unit or intensive care unit; inpatient days in acute care after assessment for long term care; inpatient surgical procedures; and day care surgical procedures. Each of these is given a weight relative to an inpatient day as 1.0, and the weighted sum of all defines the hospital's workload. Such a procedure assumes that these five categories are internally homogeneous, which they obviously are not.

As to the question of the appropriateness of care, however efficiently provided, we have made a set of recommendations, which can be found in ***Careful Spending***, that provide financial incentives for hospitals to conform to yet-to-be established standards for providing services. However, in making these recommendations, we have been concerned that incentives to improve efficiency or the appropriateness of care may represent more severe pressures on higher-cost or higher-use institutions and indirectly penalize the people who use those institutions. Moreover, the people responsible for administering or providing care in those institutions may not see themselves in the same light as the funding formula casts them. Funding mechanisms must not be the only, or even the dominant, way to improve management performance in hospitals. Instead, they should serve to support education and consultation between hospitals and the Ministry of Health, which in turn must be based upon a great deal more shared information.

Therefore, the commission recommends that:

4. **the operational review activities of the Ministry of Health be expanded to include assistance to hospitals by the introduction and application of utilization standards, the development and use of comparative cost information, and by helping with the overall management of the institution.**

The process of funding hospitals and setting guidelines must be open to the public which at present tends to believe that in health care "more is always better." Little or no effort has been made to explain the need to shift resources from acute care hospitals to the community. As a consequence, a substantial proportion of the public lends its support to the current patterns of hospital use and to continued hospital expansion. Virtually all of the publicity coming from the health care system supports business as usual. But the request for more is met by the dour financial response, "We can't afford it."

The province can afford more if that is what is really wanted. But to afford more, British Columbians will have to give up other things which they may feel are important. The key point is that the province can do much better with the resources already devoted to health care. But this point is not being communicated, except in the most general terms. On specific issues, the public pressure is always for "more".

We believe that the public is more likely to support new directions if it is told what they are, and why they are being taken. The ministry and the various associations of health care providers must find a way to stand together on these issues. Continuing conflict over standards of care will eventually undermine public confidence in the health care system. We hope that the Health Council recommended by this commission may be able to encourage and negotiate the necessary cooperation.

Therefore, the commission recommends that:

5. **the Ministry of Health begin, in cooperation with the BC Health Association and the medical profession, a public education campaign which includes information on**
   a. **the appropriate use of hospitals;**
   b. **practice guidelines; and**
   c. **the present patterns of use and the overall policy of moving people and resources out of hospitals.**

Hospital Mandates

Hospitals must coordinate their activities if the collection of all the services they offer is to add up to a coherent system, with minimal gaps and overlaps, which meets the needs of British Columbians. Yet submissions to the commission have described hospitals closing wards and clinics which were the only source of care for certain types of problems without any effort being made to coordinate these closures with other hospitals in the region or to ensure that people needing these services were covered. In some cases, hospitals have apparently decided to cease providing a particular service, without any sense of accountability to the community which supports them or to those for whom they are responsible. This is totally unacceptable and we are concerned that, as cuts are made in acute care capacity, such situations will become more common.

Under our proposed modifications to the funding formula, any hospital which closes facilities or ceases to provide certain services would automatically lose a portion of its funding. Furthermore, any institution which began to provide a service abandoned by a hospital, from within or outside the region served, would receive the corresponding funding. This incentive, however, may not be sufficient to prevent gaps in health care services from appearing.

Therefore, the commission recommends that:

6. the Ministry of Health, working with regional advisory boards, define the mandate for each hospital, free-standing clinic and other non-hospital-based care providers in each region of the province, clearly specifying the functions that each will perform and the population that they are expected to serve.

This would avoid the possibility of an independent facility *cream-skimming*, i.e., selecting the simplest and most profitable cases while leaving the complex and difficult ones to others. These mandates could also assign exclusive rights to provide certain services. One hospital might be the regional centre for hip surgery, while another might provide ophthalmology.

Hospitals would no longer be able to initiate or terminate services solely at their own discretion. The hospital's mandate and catchment area would then be major considerations when it decides on the size and composition of its medical staff.

Ten percent of our admissions to acute care beds have been for people who really require mental health services that could be provided in the community.
HOS-050

Quality Assurance and Utilization Management

An argument can be made that developing standards for common hospital procedures is part of the general area of *quality assurance and utilization management. By definition, unnecessary care is poor quality care. Care provided in an inappropriate setting is poor quality care at the system level, even if not at the level of the institution. Quality of care, therefore, includes doing things right, and doing them in the right place. But, while strictly correct, this broader definition of quality assurance and utilization management could blur the meaning of what the commission recommends.

Traditionally, quality assurance has tended to focus on a particular case, an individual practitioner, or an isolated institution.

- The management of a case is evaluated against expert judgement of the best practice that could be applied to that particular situation.
- Individuals are given credentials on the basis of their education, on their display of competence at a given point in time, and perhaps also on evidence of participation in approved professional activities.
- An institution is accredited on the basis of its facilities and equipment, the number and qualifications of its staff, and the form and activity of the committee structure.

The questions we asked to arrive at the recommendations in this chapter are based upon statistical measures: e.g., "Out of all patient days in acute care, how many were inappropriate?" It is true that we examined 460,587 individual records of separations from BC hospitals, but the data we looked at are much more limited than the medical information a clinician would need before making a judgement on any one individual case. Our results describe a pattern, not a single incident.

Furthermore, the inappropriate use which we have identified is not attributable to the inadequacies of any individual or hospital, much less to deliberate misbehaviour, although either or both of these things may apply in some particular cases. Instead, we think that inappropriate use results from the decisions of competent and conscientious people acting in what they believe to be a responsible manner.

This means that solutions are not going to be found in more education of, or better behaviour by, individuals. Utilization management at the level of the hospital may help, but utilization management will not recognize inappropriate use that has become the standard of practice for an institution.

The special problems of hospitals are primarily with overall patterns of use, and the correct handling of specific individual cases will not necessarily lead to an effective system. The solutions lie in more general interventions: population–based caps on expenditures, lower bed-to-population targets for hospitals, changes in funding formulas, and province-wide standards, collectively developed and applied to each institution.

Hospital Issues – A Selection

There is very strong and broadly-based support for the principle which we have called "Closer to Home". But there is much less recognition, at least among submissions, of the corresponding need to shift people and resources out of the acute care sector. A number of other issues are raised a number of times, in different communities. Some are quite contentious.

Quality assurance and utilization management, in hospitals and out of them, are discussed in more detail in ***The Best Care***.

•Hospital Boards

Most hospitals fall under the Society Act, which sets out how members of a hospital society can become trustees of the hospital board. Under the Hospital Act, the Minister of Health can appoint at least one person to a hospital board and a representative to a *regional hospital district.

According to a recent BC Hospital Association (BCHA) survey:

- the size of hospital boards varies from two to 25 trustees, with a mean of 11.6 trustees
- 57 percent of trustees were elected, mainly by the hospital society
- 76 percent of the boards had a majority of their trustees elected, 18 percent had a majority of trustees appointed, usually by either the provincial or the local municipal governments, and 6 percent had an equal number of elected and appointed trustees.

A number of people in BC oppose electing hospital board trustees at annual society meetings as this sometimes results in a special interest group dominating a board. Other people favour all appointments being made by either the Minister of Health or the local civic government. Still others recommend the election of hospital boards in the same way that school boards are now elected. This last proposal was strongly disputed in a number of hearings and we do not think it could be easily applied to all hospitals or communities.

However, we do think that all of the members of a community served by a hospital should be recognized as members of that hospital's society and should be eligible to vote. Only one community hospital has taken this approach so far, but the commission believes that it is appropriate. We disagree with suggestions that board members should be compensated, though, and think that physicians who practice in a hospital, hospital employees and people who do business with a hospital should not be eligible for election or appointment to that hospital's board. The conflict of interest is too clear to be argued.

Therefore, the commission recommends that:

7. a. all members of the boards of trustees of tertiary care hospitals be appointed by the minister of health. Where the hospital is also a community hospital, some of the minister's appointees shall be taken from nominees of the district or municipality; where the hospital is also a major teaching hospital, some of the minister's appointees shall be taken from nominees of the University of British Columbia;

b. one-third of the members of the board of trustees of community hospitals be appointed by the minister from nominees of the district or municipality; one-third be appointed at the discretion of the minister from the community; and one-third be elected by members of the hospital society;

c. a hospital operated by a religious group shall have some of that group's nominees included among the minister's appointees; and

d. no person who works in, works for, holds privileges at, or has business dealings with a hospital is eligible for election or appointment to that hospital's board of trustees as a voting member.

8. all adult residents of the community which the hospital serves shall be deemed to be members of the hospital society, and voting shall take place by secret ballot at a polling station open during the day and evening on the date of the society's annual general meeting.

• *The Mix and Qualifications of Hospital Personnel*

This topic is central to the recommendations in this chapter and in ***Careful Spending.*** We focus here on specific aspects which are less emphasized in other chapters.

Many submissions to the commission reflected the persistence of territorial disputes between different occupational groups in and out of hospitals. Health care seems to be particularly plagued with struggles over who shall be entitled to hold certain jobs or perform certain functions. The advantage in these conflicts always appears to be held by those groups with more extensive training or higher credentials, and academic degrees bring exceptional power. Demonstrated capability to perform a function seems to play a minor role, if any, in these disputes.

The advantage conferred by higher training distorts the whole educational process. The need for education – formal, credential-granting programs in particular – is often determined by the pressures of interoccupational rivalry and aspirations for professional status, rather than by the requirements of the job. This was reflected in a number of submissions from hospital workers which called for more financial support for educational leaves of absence, so that individuals could go away on extended training programs and acquire additional credentials. Registered nurses (RNs), for example, finding their career development blocked by formal or informal baccalaureate requirements, requested this type of support, as did licensed practical nurses (LPNs) who felt that their jobs were being taken away by RNs.

By contrast, the trend in much of the rest of the working world is toward lifelong learning in the workplace. Short courses, in-service training, close integration between training and application with an emphasis on flexibility to keep up with a fast-changing environment, all seem to be the dominant ideas in the corporate sector. The one-time extended program, taken outside the working environment to acquire a clearly defined credential, appears less well adapted to the needs of the modern workplace. The emphasis on continuing education, lifelong learning and career development is well placed. But linking this and the traditional credential granting process seems out of date and motivated primarily by the struggle for professional advantage, not by the needs of the job. The hospital should be the site of education. And access to roles and jobs should be determined by demonstrated competence, not by the possession of a credential.

One of the most frequent arguments made before the commission came from the Hospital Employees' Union (HEU). According to HEU submissions, the number of LPNs employed in hospitals has dramatically declined in recent years and their positions have been taken by RNs. Representatives of LPNs claim that there is a substantial overlap in the roles of these two groups and that the substitution of higher wage RNs has added to hospital costs without benefiting the quality of care.

LPNs trace this change to the primary nursing care philosophy replacing the team concept. They claim that nursing leadership wants to promote the professional status of nursing by supporting the idea that nurses, as professionals, should have the power to define their own field of practice, as physicians do, and then to call on whatever resources are necessary to carry out these self-determined tasks. According to this philosophy, "professional" nurses do something quite different from the merely technical tasks of LPNs.

This argument suggests that nurse administrators have been able and willing to use their positions in hospital management to advance the status and employment prospects of RNs at the expense of both LPNs and the public who must pay the extra costs. But it was also pointed out to the commission that in the mid-1970s the wages of LPNs rose substantially faster than those of RNs, almost eliminating the gap between them. Since RNs can perform a wider range of functions, and can generally work more independently, any responsible administrator would have preferred to employ RNs when the wage rate was similar. The decline in employment of LPNs may simply reflect a natural response to relative costs. If this is the explanation, then we expect the trend now to be reversed. During the 1980s, the RN/LPN wage gap has widened again, opening up significantly at the end of the decade.

RNs who appeared before the commission have not generally cited wage differences in responding to the claims of LPNs and the Hospital Employees' Union. Instead, they focused on educational differences, arguing that the increasing complexity of the hospital work environment has raised more and more of the nurse's role beyond the competence of the LPN. This claim is strongly rejected by LPNs who allege that individual hospitals, or their nursing departments, have placed arbitrary restrictions on the tasks LPNs are permitted to perform. They claim that they are prevented from working to their full training and capacity and are, in effect, being *de-skilled*.

A similar issue arises from the proposals of the Canadian and provincial nursing associations to make a baccalaureate (BScN) in nursing a minimum requirement for entering nursing practice by the year 2000. A small number of submissions went so far as to recommend that an increasing number of nursing functions in hospitals should really be performed by people with post-graduate university degrees. Again, the underlying rationale is the increased complexity of nursing practice.

The two issues of replacing LPNs with RNs, and RNs with BScNs, are parallel. In both cases, there is pressure to substitute more highly trained for less highly trained personnel. The arguments are the same; the nature of the work has changed, so that quality of care now requires more training, more credentials – and higher wages.

One staff nurse said, "Our employer strip-mined our physical and emotional resources." IND-105

The commission also received a number of submissions from nursing representatives on the subject of non-nursing duties – activities which nurses feel should be performed by other personnel so that nurses have more time to practice nursing. The argument, as we understand it, is not that such personnel should be hired instead of nurses, but that they should be hired in addition to nurses.

The commission is concerned, however, that job definitions and task assignments tend to become rigid and to interfere with the effective functioning of the health care system as a whole. In smaller communities, and on late shifts in particular, the people who are available have to do the things which need to be done.

As we have already stated, a central objective of our commission is to transfer patients, jobs, and money out of the acute care sector. But it will be impossible to achieve this transfer if inter-occupational disputes and professional aspirations result in a substantial increase in the finances required by hospitals. Substituting more highly trained for less highly trained and costly nursing personnel, and adding more support personnel to permit an expanded scope of nursing practice cannot be reconciled with down-sizing the acute care sector to free up more resources for home and community-based programs.

Having recommended a 25 percent cut in acute care use, we anticipate that the remaining patient days will be provided to patients who are sicker, on average, since we expect the less severely ill to be transferred to other facilities or to home care. Care requirements for each patient day will probably increase and it is well understood by the commission and everyone else that acute care budgets cannot be expected to fall by 25 percent. But they can be expected to fall, because the total workload of the acute care sector will have been reduced.

What we wish to warn against is the argument, made in some submissions, that the increase in the average costs for each patient day for the remaining case load will absorb any savings from reduced use. Elementary arithmetic makes this impossible, unless the increase in the average severity of acute care cases is used as an opportunity to increase the costliness of the care provided to the remaining patients.

Yet this is precisely the structure of a number of the arguments presented to the commission. Patients are sicker, so more people with more training are required to care for them and more support staff are needed to do non-nursing duties. Reducing acute care bed use may, therefore, induce even more energetic pressing of these arguments and more requests for funding.

The hospital is a place to care for patients. It is one place among many, and the role and scale of the hospital system should follow from and be determined by decisions as to the most appropriate forms of care for patients. If a hospital is used as a job fortress, or a ladder to enhanced professional status, the effectiveness of the whole health care system will be compromised. The restructuring and the reform, which the commission has been told, and believes, are necessary, will fail.

This topic – the necessary qualifications and the appropriate mix for hospital workers – including the commission's recommendations on the baccalaureate 2000 program currently supported by the Canadian Nurses Association and the Registered Nurses Association of BC, is dealt with in ***Health Care Personnel***. A discussion of the seemingly endless and universal turf wars in health care can be found in ***Governance of the Health Care Professions***.

• *Inappropriate Use of Emergency Departments*

A number of submissions to the commission were concerned with the misuse and overuse of hospital emergency departments. They suggested that:

- some physicians abuse emergency departments by using them to extend their office hours, or as clinics
- the elimination of deterrent charges to patients in emergency departments has resulted in excessive use and overcrowding
- some physicians and patients use emergency departments as a way to jump the queue for inpatient admission.

Here, people come to the emergency department for everything from a bang nail to a sore throat.
HCP-073

It should be emphasized that in the overall provincial system of health care these problems are not very large. No one has suggested that the misuse of emergency wards is threatening the care of the patients with true emergencies, and several people pointed out that staff are quite capable of distinguishing non-emergent cases from true emergencies, and caring first for the emergencies. As well, emergency wards probably consume 5 percent or less of hospital budgets, so their misuse or abuse would have an effect on total costs measured in fractions of a percent. Nor do we have any evidence as to the scale of the problem of abuse, by either patients or physicians.

While small fractions of a very large number may still be quite large, we suspect that the real reason for the attention devoted to the misuse of emergency wards is that it is an irritant out of all proportion to its share of a hospital's workload or expenditure. The patient who calls an ambulance and arrives with a small cut or an upper respiratory infection understandably generates a sense of outrage among people who take their work seriously. And the story circulates for a long time.

In the same way, a physician who refers patients to an emergency ward for non-emergency, after hours care, uses the hospital's facilities and support staff, and then claims a full after hours fee from MSP, leaves hospital staff feeling used. The MSP fee schedule includes an allowance of between 40 and 50 percent for office and other overhead costs of physicians. But the physician who sees patients in an emergency department collects the whole fee, while the overhead costs come from the hospital's *global budget. Resentment is understandable.

The most common remedies suggested to the commission were:

- a reinstatement of user fees for emergency ward use
- a requirement that physicians who see patients in hospital emergency wards return to the hospital a portion of their fees equivalent to the MSP overhead component.

However, both of these proposals would penalize appropriate behaviour as well as inappropriate behaviour.

There are several appropriate ways in which physicians in office-based practice may use emergency departments and still receive a full fee. For example, the physician who is called away from the office during practice hours by a call from the emergency ward is entitled to the full MSP fee, because the physician's office remains open and staffed during the physician's absence. In the same way, the physician who is called to an emergency in the middle of the night should not be charged for the use of the hospital's facilities, because the emergency ward is, after all, staffed on a 24-hour basis for just this purpose.

It may be a different matter if the physician refers patients to the hospital for non-emergency care, particularly if scheduling after hours patients there becomes a practice. But we must be very clear about the meaning of ***abuse***. Each hospital must be ready at any time to deal with an emergency, and staff are on duty at all times. But at night, and particularly in smaller communities where the emergency ward is not continuously in use, caring for a non-emergency patient may not impose any extra costs on the hospital. In fact, from the point of view of the health care system as a whole, it may be entirely appropriate for office-based physicians to see some of their patients in the evening at an emergency ward, for the obvious reason of patient convenience. If so, why not use a hospital where the facility is up and running, rather than incurring the additional expense of calling in office staff and running a separate clinic? We have been told that in some communities it is much more expensive to see outpatients in the hospital than in private offices, but we suspect that this is not true when use is made of staff and facilities which are already available and paid for.

We believe that it is appropriate to use hospital emergency rooms for non-emergency cases requiring treatment that is medically necessary, after hours and at other times when family doctors are not available, particularly in rural areas. But if physicians are, in effect, using a hospital emergency ward as a clinic, it seems appropriate that they contribute to the costs of running that clinic. We hope that this fairly straightforward idea can be accepted in principle and that the various parties can come to mutually acceptable arrangements.

Therefore, the commission recommends that:

9. when, in the opinion of a hospital, a physician is using its emergency department as an outpatient clinic by directing patients with non-emergent conditions to the emergency department, and when no mutually satisfactory arrangements can be reached, the hospital may request the Medical Services Plan to transfer to the hospital one-third of the fees otherwise payable to the physician for services provided in the hospital. These payments to the hospital must be additive to the budget received from Hospital Programs.

The concern about patients making inappropriate use of emergency wards identifies two different issues:

- people seeking care they do not need
- people with a legitimate need for care which could have been met in a physician's office.

The first issue is part of the more general question of patients seeking care which is not medically necessary, whether in a hospital emergency ward or in a physician's office. We have dealt with this in ***Careful Spending,*** and our recommendations there can be applied to emergency ward use as well.

Therefore, the commission recommends that:

10. the monitoring and analysis of patients' patterns of ambulatory care use, and consequent processes of patient assignment and education, be extended to include use of hospital emergency and outpatient wards.

We expect that the use of emergency wards by people not in need of medical care will be found to be attributable to a very small proportion of the population. However, we are told that people who present with problems which require some medical care, but are in no sense emergent, are more common. In this case, the hospital is in effect being used as a walk-in clinic with more convenient hours and more immediate access than a physician's office.

This pattern of use can be attributed to either inappropriate patient behaviour, or an inflexible and unresponsive *primary care system. Many physicians believe strongly that every patient should have a family doctor and should go to that doctor for non-emergency care. But many people do not have, or do not seem to want, such a continuing relationship. They seem to prefer the convenience of a walk-in clinic with extended hours. A number of such clinics have already opened in larger communities.

* GLOSSARY

Providing care at the patient's convenience is not necessarily inappropriate, even if many of these problems do not require the care of a physician, either immediately or at all. In smaller communities the hospital emergency ward can play the role of a walk-in clinic if that ward is not at the time dealing with an emergency. Cuts and scrapes, respiratory infections or, as we were told in one community, giving the patient an acetaminophen tablet, can be handled well by nursing staff. Difficulties arise if a physician must be called out of bed at two o'clock in the morning to do what an on-duty nurse could easily have done. Such an incident can produce a disproportionate degree of irritation.

If large numbers of patients are using the hospital as a walk-in clinic, then perhaps it should be one and be reimbursed as such, with a physician holding office hours there. At present, a hospital cannot be reimbursed by MSP for services provided when the physician is not there. But if the problem is large enough – which we suspect it is not – then MSP might consider making payments to certain hospitals for services in lieu of physicians' services.

We talk about the cost of the health services.
We blame the increased cost, it seems,
on physicians, on nurses, on progress
in medicine, on patients, on everybody
we can blame.
But what about the amount of administration
and the cost there?
If it does not communicate well?
If it doesn't work well?
Is that not expensive?
SOC-331

• *The Growth of Hospital Administration Costs*

The cost of hospital administration, like the misuse of emergency wards, is more an irritant and a flash-point for other forms of discontent than a problem in its own right. The submissions cite rapid increases in the costs of administration — salaries, numbers of personnel, space, equipment, facilities — which they argue are well in excess of increases in expenditures for clinical care. There seems to be general agreement that administration is, at best, a necessary evil. Some might agree with only half of that statement.

We think that the health care system in general, and hospitals in particular, are distinctly under-managed. We believe that a good deal more accountability for the use of resources can lead to a system which is more effective overall, without large infusions of new money. Therefore, we reject the view that the Canadian health care system, either in institutions or in government regulatory and payment agencies, suffers from an excessive burden of administrative overhead. Indeed, we suspect that some complaints of excessive administration may be because administrators are beginning to do their jobs and are requiring greater accountability.

Nevertheless, we understand that increased administrative spending, by itself, does not necessarily lead to better management, any more than increased spending on health care necessarily leads to better health. We have only to look to the experience of the United States to see how explosive increases in administrative costs, "costs without benefits", can occur with no improvement in system performance.

This is a sensitive issue and is likely to become more so as the relative scale of the acute care hospital sector is reduced and managerial tasks become more demanding. We have recommended in ***Careful Spending*** that the ministry require hospitals to apply common accounting guidelines so that inter-hospital comparisons of the costs of particular procedures can be done. Common accounting guidelines should also make it possible to compare the costs of administration in different institutions over time. We have also recommended that standardized information be provided in hospital annual reports to the public. This information should include administrative costs.

• *Annual Reports*

The Society Act requires that hospitals disclose their financial statements to members of a hospital society. Some hospitals have taken the initiative and use this requirement to publish annual reports and make them available to the public. However, there is no provision in the Hospital Act which specifically requires that a hospital publish and make available to the public an annual report documenting all its activities for the past year. The commission believes the public has the right to know how its money has been spent.

The report should cover a full range of activities performed by the hospital including, for example, information on the hospital's programs to promote organ and tissue retrieval for transplantation, and its numbers and rate of successful retrievals as well as information on the use of inpatient beds and nursing services. We believe that the production of sufficiently detailed annual reports would help to ensure hospitals work to achieve their mandates.

Therefore, the commission recommends that:

11. the Hospital Act be amended to require that every hospital must publish an annual report documenting its activities of the past year and make copies of that report readily available to the public.

HOME CARE

The importance of self esteem and independence to the quality of life cannot be over emphasized.

In dealing with the aging part
of our population we tend to forget
that in those years they deserve the right
to live out their lives with a feeling of self-esteem,
self-respect, of having some real reason for living.
We are of the opinion that the facilities that
we develop and the services that we develop
should be those types of services
that will enhance the possibilities to do that.
HUT-032

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Family, Friends and Neighbours

A clear message received by the commission is that, whenever possible, care provided in the home or on an outpatient basis is preferable to institutionalization.

According to a recent Ontario study, informal caregiving by family, friends, neighbours and volunteers provides up to 90 percent of the assistance required by dependent people. The caregiver is usually female, usually the spouse or an adult daughter of the dependent person. Professional caregiving only supplements and supports this informal system.

There are many costs involved with keeping people in institutions, and from a quality of life as well as an economic perspective, we must encourage home and *community care. Whether *home care is viable, however, depends largely on the resources that support it, and the government must be prepared to commit a realistic portion of its funding to care in the community. We think that the savings which will result from a reduction in the use of *acute care hospital beds and institutionalization will offset the costs necessary to supplement home care. But this belief, discussed in ***Careful Spending*** and ***Hospitals,*** is based on the assumption that there will not be an increase in physician services and that some acute care beds will close.

The health care system must give appropriate and practical support to informal caregivers or they will burn out. This means that both the caregiver and the care-receiver need help from the health care system. They need practical information and education, and they need to be supported emotionally through what is often a difficult and lengthy period in their lives. Community-based caregiver support groups currently attempt to fill this need and the government should encourage and assist them, and require agencies to do the same. As the Vancouver Health Department's *submission to the commission remarked,

> *without the participation of the informal support system, increased costs to government would be immense and possibly unbearable.*

Therefore, the commission recommends that:

1. **the Ministry of Health**
   - **a. redirect funds from acute care to home care;**
   - **b. increase communications and enhance cooperation between formal and informal service providers; and**
   - **c. promote the development of caregiver support groups throughout the province.**

Funding

The Continuing Care Division of the Ministry of Health provides home support services, including *homemakers, adult day care, nurses, physiotherapists and occupational therapists, to clients throughout the province. These services are administered through the 16 provincial *health units and five municipalities.

The Continuing Care Division contracts directly with 130 homemaker agencies: 27 percent are for-profit firms and 73 percent are not-for-profit. All nursing services are not-for-profit.

A test of the family's income determines if the client must contribute to homemaker services. The assets of the family are not considered in the test, and the family income is not considered if the client is handicapped. Recipients of the Guaranteed Available Income for Need (GAIN), war allowance, or provincial social assistance are automatically exempt from contributing.

Fewer than a quarter of all clients contribute to the cost of homemaker services. The average contribution is less than $40 a month. The client does not share the cost of nursing, adult daycare, physiotherapy or occupational therapy.

The federal government shares the cost of not-for-profit homemaker services through the Canada Assistance Plan.

Services in Rural Areas

It was clear from the submissions to the commission that there are fewer support services for community care in the more remote areas of the province. This results in hardships and anxiety for residents of rural and remote areas of BC who must live with chronic disabling conditions.

Therefore, the commission recommends that:

2. **the Ministry of Health improve support for home care in smaller rural communities.**

Geriatric Assessment Services

There are some good geriatric and psychogeriatric assessment programs in the larger urban centres, although some practitioners may be unaware of them. These programs offer the elderly — particularly those with complex health problems — valuable support. In smaller communities, people may have to leave their homes and support systems to be assessed.

People usually attend geriatric assessment programs two days a week for about six weeks. While there, they are provided with social stimulation, a nourishing meal and an assessment of their health, functional ability and medications. Both the family and the family physician are involved in the assessment along with an interdisciplinary assessment team. At the end of the program, options are discussed and recommendations are made to help the person remain independent and in the community.

FUNDING OF SUPPORT SERVICES

	Homemaker	Nursing	Physio/Occupational Therapy
Ministry of Health	✔	✔	✔
The Federal Government's Canada Assistance Program[1]	✔	×	×
Client[2]	✔	×	×

[1] CAP contributes to Homemaker Services provided by not-for-profit agencies to clients who receive GAIN (guaranteed income supplement), or war allowance. The plan used to pay 50% of eligible expenses but now pays a maximum of the previous year's funding plus 5%.

[2] As determined by client's annual income, less than a quarter of clients contribute; on average they pay less than $40 per month

✔ = Contributed by   × = Not contributed by

Source: Ministry of Health, Correspondence with Policy, Planning and Legislation Division.

Therefore, the commission recommends that:

3. **geriatric and psychogeriatric assessment programs be developed in communities, and mobile assessment teams be established for areas where the population cannot support a program.**
4. **health care professionals and para-professionals take advantage of geriatric and psychogeriatric assessment programs and make appropriate referrals.**

Respite Care

...24 hours today,
24 hours tomorrow.
They must have respite.
We must have
more daycare.
SOC-008

Respite, or caregiver relief, is an important service frequently requested by informal caregivers. Lack of relief, or the prospect that there will be no relief, is a terrible burden to bear.

However, to date there has been a failure to tailor respite care to needs, particularly for care-receivers with a complex illness or a dementia. The informal caregiver is much more likely to use respite services if the care-receiver reacts well to the experience. But if the respite experience is unpleasant for the ill person, then the informal caregiver will hesitate to use it in the future. Therefore, it is important that there is flexibility in the choice of respite care.

To achieve this, three types of respite care are necessary. The most widely desired is *in-home respite*, followed by *adult day care*, and then *facility respite*.

• In-Home Respite

In-home respite personnel provide care in the home to give the informal caregiver a rest. Care may be provided for a few hours during the day, overnight, or on an extended basis.

Respite is required for all caregivers on a regular basis, but it is particularly important for those caring for people suffering from moderate to advanced dementias. Often the disruption associated with moving these people to a facility for respite care has a devastating effect, traumatizing both the client and the informal caregiver. People with severe behavioural problems are also very disruptive to the permanent residents of facilities and can cause hardships for the staff.

Therefore, the commission recommends that:

5. **overnight in-home respite be provided as an alternative to facility respite in situations where the client suffers from a dementia or has special needs.**

• Adult Day Care

Many parts of the province now have daily or weekly adult day care programs. These programs are relatively inexpensive and provide respite for the caregivers as well as social stimulation and well balanced meals for the frail elderly. They also provide an opportunity to monitor physical and mental well-being.

Some adult day care centres offer supervised bathing, and provide podiatry programs, audio consultants and incontinence counselling. They also supply transportation for clients who could not otherwise attend day care. Informal caregivers can maintain an ongoing association with an adult day care program to provide them with assistance and practical advice. A Manitoba study showed that participation in these programs reduced the number of hospital stays for the frail elderly.

Therefore, the commission recommends that:

6 the Ministry of Health
  a. support adult day care centres and encourage their development throughout the province;
  b. encourage adult day care programs to be sufficiently flexible to meet the needs of the client and informal caregiver;
  c. support programs that provide advice and assistance to enable the community-dwelling seniors and informal caregivers to remain as independent as possible; and
  d. require that *long term care facilities with special equipment that is not fully used (e.g., century tubs), be made available to community-dwelling seniors.

• *Facility Respite*

Facility respite is more often available in urban centres than in the rural areas of the province. Ideally it includes assessing the person's mental and physical status and monitoring medications. Facilities must be sensitive to the particular requirements of different cultural and ethnic groups, including Native Canadians, if there is going to be proper access to this type of care. The particular needs of these groups are discussed in ***Immigration and Multicultural Health*** and ***Native Health.***

Therefore, the commission recommends that:

7. facility respite
  a. include an assessment component when appropriate; and
  b. be matched to the special needs of the individual and the family.

Convalescence

Discharge planning is a key to the appropriate use of hospital beds. Yet different acute care hospitals and, in fact, different wards in hospitals, have their own ad hoc procedures for discharge planning.

Discharge planning should take place for every person admitted to hospital whether home care is needed or not. Without such an approach, some people will go home without the support they need to ensure that they are not readmitted soon afterward.

Therefore, the commission recommends that:

8. discharge planning
  a. take place for every person admitted to hospital;
  b. involve the informal caregiver; and
  c. involve home care agencies in any case concerning a client that requires support upon returning home.

* GLOSSARY

Facility Placement

Although we prefer that the chronically ill be cared for in the community, we recognize that this does not mean they will never need institutional care. If and when that time comes, informal caregivers may actually need to be encouraged to stop being responsible for providing care and allow others to take over. ***Caregivers often need help when placement in a facility becomes necessary for someone they have cared for deeply.***

It was with great despair that I accepted the fact that extended care was the only placement available. There were no choices. The first few months were horrifying for me - visiting my 19 year old in an old people's hospital...
IND-322

Current waitlisting procedures for facilities present a dilemma to many people. Admission to one of the more desirable long term care facilities can require being waitlisted for up to two years. People are often concerned about their ability to cope so far into the future, and therefore they waitlist the frail elderly person well in advance. They then live in constant fear that an emergency will force the person into a transitional facility.

Once the care-receiver's name comes to the top of the waitlist, the move must be immediate or the person will be dropped to the bottom of the waitlist and the process will begin again. This causes many families to move the care-receiver to the facility even when the informal caregiver might be prepared to carry on. Waitlisting is also discussed in ***Long Term Care,*** where we recommend that a person be able to postpone going into a facility without being moved to the bottom of the waitlist.

Financial Costs

A number of submissions expressed concern about "disincentives" to home care, such as the high cost of medical equipment and supplies, and some medications. This problem adds to the burden of caring for the chronically ill and is discussed more fully in ***Palliative Care.***

Therefore, the commission recommends that:

9. where the client is eligible for admission to an institution, costs for equipment, medical supplies, medications, transportation, home support daily fees, etc. be reduced to equal those incurred if the client was in a facility.

Home Care Nursing

*Home care nursing services can be valuable for some convalescents and for those with chronic disabilities, including the frail elderly. A number of submissions describe home care nursing as a cost-effective program that enhances the quality of life of patients by increasing independence and allowing them to remain in the community. It may also help to free up acute care beds and reduce the pressure on hospital outpatient departments.

Home care nursing services, however, appear to be less appropriate for disabled clients whose work dictates that they cannot wait for an unscheduled visit. Furthermore, when we visited small communities we found that the way nurses are organized can hamper services. For example, the *public health nurse, the home care nurse, the Long Term Care case manager and the hospital or diagnostic and treatment centre nurse are not permitted to perform each other's work. They work independently of one another which is inappropriate. As discussed in ***Health Care Personnel,*** nurses must be able to function in more than one role.

Therefore, the commission recommends that:

10. the provincial health care personnel plan address the shortage of home care nurses in remote areas.

11. home care nursing services be tailored to need, e.g., clients who work should be provided with prescheduled appointments.

12. to eliminate duplication in large communities and to provide services in small and remote communities, provisions be made for a nurse to render more than one service.

Home Care Workers

Home care workers provide support to the frail elderly and other adults in the community who require help to be independent. Home care personnel work relatively independently and often at irregular hours as they move from home to home. Homemaker agencies have supervisors and nursing staff as backup, but, in general, these workers must use a high degree of personal discretion. They need special training if they are to work with people suffering from dementias, with *extended care clients, or with the terminally ill.

Standardized performance requirements that can be measured are needed to help agencies and workers understand the ministry's expectations of them and to make them more accountable for their services. However, quality control standards have yet to be established and, as mentioned in ***Long Term Care***, current home support training programs do not include a geriatrics component.

The cost of home care is minimal compared with the cost of institutional care. However, the employee turnover rate is very high. The discrepancy in wages between home support workers and long term care aides working in facilities should be reviewed. Equitable wages and benefits, good training and orientation, and recognition of the importance of their services are all essential if appropriate candidates are to be attracted to and retained in this industry. Home care worker wages are discussed in more detail in ***Services to People with Disabilities.***

Family caregiver work is unpaid, and done at considerable personal cost - physical, emotional and financial.
SOC-058

Therefore, the commission recommends that:

13. a. home care workers' salaries and benefits be adequate to attract and retain competent staff;

b. there be improved orientation and in-service training to ensure that home care workers have the required skills, including training in the area of geriatrics and psychogeriatrics; and

c. clear, measurable quality control standards be developed.

A number of people feel that the client or the family should be allowed to hire home care staff directly, either through an agency or privately. Under this system, the long term care case manager would still decide the number of hours to be provided to a person, while increasing the care options for the client and informal caregiver. It might even make sense in some circumstances to hire a family member, who would otherwise be employed out of the home, as the home care worker.

Therefore, the commission recommends that:

14. **care-receivers and informal caregivers be involved in care planning as full partners with health care professionals.**
15. **a procedure be established to allow clients or informal caregivers to hire home support workers directly. In appropriate circumstances, a family member might be the paid home support worker.**

It is important that care-receivers and their families have as much power as it is possible for them to have. They should not lose their independence to a home care worker, and the home care worker must not assume control. Case managers, who strive to provide the highest quality service, seem to determine which agency the care-receiver will use. The agency, in turn, decides which specific worker will provide the care. This can make it difficult for care receivers and their families to find an agency and a worker they are comfortable with, even when there are a number of agencies in their community, thus reducing the value of the service.

Therefore, the commission recommends that:

16. **so far as is practicable, the home care client should have the right to change worker or agency.**

Access to Information and Services

Many people cannot use health care services because the services are not physically accessible to them. Community centres, mental health boarding homes, residential facilities, halfway houses, emergency shelters, and alcohol and drug treatment centres should all be adapted to provide access to disabled and chronically ill people. People with special communication needs must also be considered.

Government and facility policies need to be reviewed to reduce unnecessary bureaucratic procedures. Access to information about the availability of services and access to the services themselves must be improved. The current maze of information can be daunting for anyone. It can be an impenetrable labyrinth for the disabled and the sick, or for the family member dealing with a crisis.

Therefore, the commission recommends that:

17. one contact point be established and publicized to obtain information regarding home care related services.

18. there be an expeditious appeal to an independent authority against the decision of a case manager.

Education

Educational programs are needed to increase the sensitivity of health care workers to the special needs of some clients, particularly those with restricted movement, the chronically mentally ill, and the demented. There is also a need for a greater understanding of the unique requirements of new Canadians and of their cultural differences, as well as for other groups, especially Canada's Native peoples.

By
biomedicalizing dementia,
I mean
that we are
bringing
an acute care model
to bear on this problem, and it's not
an appropriate
thing to do.
SOC-086

Therefore, the commission recommends that:

19. training programs be made available for home care personnel
  a. to help them understand and support people with unique needs, particularly those suffering from a terminal illness, a chronic mental illness or a progressive dementia; and
  b. to increase sensitivity to varying cultural and linguistic needs.

20. where feasible, home care should be provided to minority groups by people of the same culture.

LONG TERM CARE FACILITIES

The commission views *long term care, *home care, day care and other assistance to the chronically ill, the frail or the disabled as one of the most critical elements in our health care system. The quality of life of many British Columbians, and the province's ability to contain the overall costs of the system, are intimately tied to this field of health care.

This paper deals with the facility or institutional portion of Long Term Care, including *intermediate care and *extended care facilities, sometimes referred to as nursing homes. In considering the issues, we have been guided by three basic principles.

- Long term care facilities are people's homes. The people are residents, not patients, and the management, the care providers and the physical layout of long term care facilities must reflect this fact.
- It is better for long term care residents to live in a less than perfect facility ***within their own community*** than to be placed in a facility which meets all of the health, safety and building requirements, but is situated away from the residents' families and friends.
- An insufficient number of long term care beds will eventually raise costs in *acute care and other areas of health care.

We are dealing with individuals
who have long and interesting pasts...
We are dealing with people whose joints are stiff,
whose bones creak when they are moved,
and who live in fear of sudden and
quick movements...
We are dealing with people like you and me,
who respond to human kindness and tenderness,
and the freedom to choose.
HCP-206

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Therefore, the commission recommends that :

1. every effort be made to ensure that
   a. long term care facilities are made into homes;
   b. residents remain as near as possible to their former homes; and
   c. there is an adequate number of long term care beds.

Sensitivity to Individual Client Needs

To make long term care facilities more responsive to their clients' needs, the government must:

- Consider the needs of current and future residents in planning long-term care institutions, particularly the needs of youthful residents and specific cultural groups. Recommendations regarding facilities for cultural groups have been made in ***Immigration and Multicultural Health.***
- Involve the family caregiver in care planning to ease the client's transition to the facility.
- Increase the use of physiotherapy and occupational therapy for intermediate care.

Therefore, the commission recommends that:

2. planning for the building and renovation of long term care facilities include the development of specific facilities for youthful long term care residents and for cultural groups.

To make a facility more like a home, a different approach is needed. Very successful facilities have found that they do not need to force their residents to dress or eat at certain times. There is a certain dignity in not being treated like a child, and dignity is an important part of life.

Making a facility more like a home may also mean changing privileges and *scopes of practice of caregivers as described in ***The Governance of the Health Care Professions.*** Residents should have greater freedom to choose who treats them, just as they would have in their homes.

Trends in Long Term Care

In 1989/90, the Continuing Care Division of the Ministry of Health spent $597 million on long term care facilities:

- $307 million was spent for 17,000 residents in intermediate care facilities, licensed private hospitals and group homes.
- $290 million was spent for 7,500 residents in extended care. This included residents in units attached to hospitals and in free-standing units, as well as long term care residents occupying acute care beds.

In addition, $110 million was spent for 42,000 patients receiving home support services.

The Long Term Care Program offers five levels of care: Personal Care, the lowest level; Intermediate Care (IC) 1, IC2, IC3; and Extended Care/Extended Care Unit (ECU).

- Almost 80 percent of the people in long term care facilities are 75 years old or older. Only 1.4 percent of the 65-74 group are in facilities, compared with 7 percent of those 75-84, and 30 percent of those 85 and over.

- As care levels rise, the number of *community care clients decreases and facility residents increase. Over 20,800 of the long term care program's 42,000 community clients in 1989/90 were at the lowest level of care compared with 1,400 of the program's 24,500 facility residents. Of the program's community clients, 2,700 are at the two highest care levels (IC3 and EC), compared with 12,900 facility residents.
- Over 9 percent of the 65 and over population used *homemaker and adult day care services. Approximately 5 percent of British Columbians 65-74 years of age, 14 percent of those 75-84 and 22 percent of those over 85 received Community Care from Long Term Care.
- Expectations about when people should be institutionalized have changed over the years. Case managers – whose job it is to assess clients, coordinate services and undertake *quality assurance – and caregivers are increasingly knowledgeable about ways to maintain people at home.
- The proportion of nursing home residents who are sick, confused, or have a dementia has increased significantly. Higher, more intensive levels of care are required for those facility residents.
- More disabled people at lower care levels are living in private-pay facilities, reflecting an increase in difficulty in entering a publicly-financed facility at a low-care level.
- Overall, the rate of use of long term care services appears to have stabilized since 1984/85. While the use of facilities has gone down, home support has risen and homemaker services have been substituted for lower levels of facility care. At the same time, the Ministry of Health has contained home support service use by reducing the hours available for each user.
- Real (constant) long term care expenditures rose by 33 percent between 1982/83 and 1989/90 but expenditures for facilities rose faster than those for home support service. A 36 percent increase in facility expenditures was due to 9 percent more beds, more staff because of higher care levels, and higher wage rates. A 13 percent increase in homemaker expenditures was due mostly to more hours and higher wage rates.
- The policy of eliminating personal care level beds and substituting home support services has helped the system to cope with the larger numbers of residents requiring heavier care. However, an end to this benefit is foreseen, as discussed in more detail in ***Careful Spending***. More beds will be needed since the 75-84 year old group will increase by 36 percent, and the 85 and over group by 51 percent between 1990/91 and 1999/2000.
- As average care levels rise, staff levels and the professional mix will change. Special care units, *multi-level service care, geriatrics education and staff training will all increase expenditures, as will any reduction in the gap between non-union and union wages and benefits.
- Home support service expenditures will also increase due to population increases, substitution of community care for lower level facility care, and an increased need for training in geriatrics. Wages for home support workers may also rise to counteract shortages and high turnover rates. Caregivers for the demented may also demand greater access to respite care. Long term care facilities can help those who remain in the community with respite services, and day care services, which include access to special equipment and trained personnel. The walls between facilities and the community must be breached.

We need a comprehensive plan for the care of the elderly to be put together for the province as a whole.
PRO-014

* GLOSSARY

Therefore, the commission recommends that:

3. **long term care facilities provide services to people from the community who might otherwise be institutionalized.**

Decision-Making Authority

The control of the *continuing care services and long term care programs is too diffuse. It inhibits efficient management. The Continuing Care Division currently manages intermediate care facilities while Hospital Programs Division manages extended care units. Although Continuing Care and Hospital Programs managers appear to coordinate overall resource allocation, they use different methods to determine their long term care bed supply, staffing needs, funding levels, facility designs and quality assurance.

As long term care and acute care are fundamentally different services, expertise in one area does not mean expertise in the other. Nevertheless, most extended care units are attached to, and managed by, acute care hospitals. Because funds for these units come out of global hospital budgets, the units' resources and the quality of the care available depend on the importance the acute care hospital places on long term care.

> *It would*
> *be ideal*
> *if we could have*
> *a more comprehensive*
> *mix of services,*
> *if we could have*
> *an umbrella*
> *under which*
> *all long term care*
> *could come together.*
> HOS-085

Several other factors increase this diffusion of decision-making.

- The organization of the Continuing Care Division creates uncertain lines of authority below the level of director.
- The Continuing Care Division does not have sufficient authority to commit funds to back its policies or construction plans.

The Continuing Care Division, Hospital Programs Division, and Facilities Planning and Construction Division jointly decide on the need for new or renovated facilities, but no one body has ultimate authority. While the Facilities Planning and Construction Division clearly has expertise in construction, it does not have the clinical or quality of care expertise to justify its ability to decide which facilities are built or renovated and who operates them.

Therefore, the commission recommends that:

4. **subject to responsibility being shifted to the regional general manager**
   a. **the responsibility for extended care units be moved from the Hospital Programs Division to Continuing Care Division so that all long term care services are the responsibility of one division;**
   b. **the Continuing Care Division ensure uniform formulas for the staffing, bed-planning, and quality assurance program for all long term care facilities;**
   c. **extended care units attached to hospitals be fiscally separated from the hospitals, except in smaller communities, with the option to purchase services from the attached hospital; and**
   d. **the Continuing Care Division exercise increased direction and control over facility planning and construction decisions.**

The Multi-Level Service Problem

Many intermediate care residents are forced to transfer to an extended care unit when they lose their mobility. As one nurse put it to the commission, residents are forced to move "when their legs stop working."

However, there is a general consensus that forced transfers damage the health of residents, particularly those people who have lived in a facility for years and have formed strong relationships with other residents and with the staff. Transfers may be tragic for couples who are split up after years of companionship, or for residents transferred away from their families and communities. Transfers also harm and disorient demented residents.

Although the severity of disabilities of facility residents has been steadily increasing over a number of years, it was only in 1987 that the Ministry of Health stopped renovating or constructing intermediate care facilities that were not designed for multi–level care and not completely wheelchair accessible. Since then, the ministry has created a committee on multi-level care and is preparing a discussion document on multi-level services. Facilities Planning and Construction has also issued draft guidelines.

- Acute care hospitals and long term care facilities have different goals. Four-bed wards and the absence of a home-like environment accentuate the medical focus of some extended care units. A more homelike setting could be created through relatively inexpensive alterations.
- The simplest way to create multi-level service care is to add extended care beds to intermediate care facilities and intermediate care beds to extended care units. In some small communities, the Ministry of Health has already built facilities with a mix of extended and intermediate care beds, all designed to extended care standards. In addition, when long term care facilities are being upgraded to meet current fire, safety and earthquake codes, a substantial proportion of these facilities could be renovated to multi-level standards with special care units for the demented.
- More physiotherapy and occupational therapy would allow more residents to retain the ability to help themselves.
- Provincial legislation needs to be reviewed and amended to require facilities to provide multi-level care. In recent years, there has been rapid growth of private facilities, some of which are not built to extended care standards, thus perpetuating the current problem.
- The present system of funding for private facilities does not provide incentives to build multi-level facilities, or to renovate existing beds.
- The separate systems for funding intermediate care facilities and extended care units also force facilities to keep two budgets and two sets of books.
- Residents and prospective residents do not have a speedy, independent process to appeal the decisions of assessors.

We believe that the transfer of our seniors to facilities 100 or more miles from their elderly spouses, and their whole community support system, is really deplorable.
HOS-193

Therefore, the commission recommends that :

5. **intermediate care facilities and extended care facilities be modified, where practical, to multi-level standards, so that one facility can meet all of its residents' long term care needs.**
6. **the Ministry of Health encourage physiotherapy in intermediate care facilities.**
7. **residents remain within one long term care facility as long as possible.**
8. **borrowing through the Health Facilities' Initiated Capital Projects Fund be available for all renovations and new construction.**
9. **expeditious appeals be available against the decisions of assessors to an independent authority.**

Education and Training

Complex mental and physical problems are often found in the elderly and the inability of health care workers to identify these problems can severely affect the quality of life for residents. It can also lead to conflicts between residents and staff, the use of chemical and physical restraints, stress, increased sick leave, injuries, and high employee turnover rates. These problems are often compounded by a lack of training among administrators, general practitioners and psychiatrists, and poor facility design.

Although care providers want the education and training of staff to concentrate more on elderly residents with dementia, depression and other mental health problems, none of the existing community college continuing care aide/home support worker programs require this component. All four licensed practical nurse programs in the province focus their attention on acute care. Only one spends some time on geriatrics. While the Ministry of Advanced Education, Training and Technology is reviewing its education programs, the creation of a uniform, up-to-date geriatrics program is being hampered by a shortage of facilities with exemplary practice to provide practical experience, and by a shortage of qualified instructors.

Inadequate geriatrics education and training is also a problem among registered nurses and registered psychiatric nurses. For example, the registered nurse programs present most of their geriatric material in the context of general nursing care for adults and there is no specific geriatric training in either the classroom or in long term care facilities. Employed long term care staff also receive little geriatric training since their employers do not receive specific funding for in-service education.

Professionals specializing in geriatrics could help educate staff. They could work with the staff who are dealing with particular types of residents, such as those who are difficult to manage. But there are currently very few clinicians who have the expertise necessary to separate the chronically demented from those with reversible dementia or behaviour problems unrelated to dementia.

We think that in many cases, the division between courses in colleges and practice in facilities can and should be eliminated. Facilities that provide the best care should serve as centres to provide classes and practical instruction for prospective and currently employed long term care workers.

Therefore, the commission recommends that:

10. the Ministry of Health
  - **a. work with the Ministry of Advanced Education, Training and Technology, academic institutions and provider organizations to improve the training of long term care personnel in geriatrics, especially psychogeriatrics;**
  - **b. develop educational material on geriatrics for staff in facilities;**
  - **c. support nursing homes with exemplary practice to help other facilities with in-service training and with travelling teams; and**
  - **d. encourage in-service training and exchanges.**

Special Care Units

In the case of demented residents, special care units can reduce anxiety and the use of chemical and physical restraints. These units can also ease the stress that demented residents place on those who are not demented. There is general agreement that the mildly demented should remain in the community or with the cognitively intact in facilities. However, the demented elderly should not be mixed with severely disturbed or nondemented residents. Mixing destroys the different environments needed by each group. It is a common problem, however, that creates stress for residents, their families and staff.

Several dozen BC facilities already have a wing or floor designated for special care. This move is supported by most groups, including the Facilities Planning and Construction Division, which has issued draft *Multi Care Design Guidelines*. Health and Welfare Canada has also produced a special care unit report, *Designing for People with Dementia*.

Despite such moves, program quality varies across the province from poor to excellent. Care providers repeatedly argue that current staffing and skill levels are only adequate for custodial care, not a special care unit. Others say that it is a question of management and design.

At the exemplary end of the spectrum is the highly regarded Oak Bay Kiwanis Pavilion in Victoria, which has created an environment which accommodates the resident. Staff develop individualized care plans, look for causes of agitation, and do not force residents' behaviour. A geriatrician medical coordinator works with the residents' general practitioners and with the facility pharmacist to reduce medications.

The Health and Welfare Canada report recommends the design of small resident clusters. Design features can be very simple, such as different colours in halls and familiar pictures in residents' rooms or on their doors to help them orient themselves. Outdoor walking loops allow residents, particularly demented residents, the opportunity to move freely, thus relieving the need for restraints. Health and Welfare Canada points out that since evaluating new designs should improve our knowledge of how best to provide care, facilities should be built to permit later alteration.

Therefore, the commission recommends that :

11. special care units be available for the seriously demented.

Long Term Care Facility Reimbursement Methods

The Continuing Care Division provides a *global budget for almost all of its facilities. Wages and benefits account for 75 percent of the total cost. For eight types of staff, the fraction of a *full-time equivalent (FTE) employee for each resident for each day varies by care level. The number of residents at different care levels determines the number of facility FTEs. Combined with an average salary for each type of staff, this determines most of the facility's budget.

> *My reimbursement*
> *is based on care levels,*
> *and the heavier*
> *the care level,*
> *the more money*
> *I get for my*
> *operating budget.*
> *And we're not*
> *rewarded*
> *if people do improve.*
> *And I feel that*
> *this attitude*
> *has to change.*
> *People do rehabilitate*
> *within care facilities*
> *and we do*
> *see people discharged,*
> *and we should*
> *be rewarded for this.*
> HOS-085

The Ministry of Health also pays mortgage costs for non-profit facilities, and an inflation-adjusted flat rate each day for each resident to proprietary facilities. Residents currently pay facilities $22.80 per day, or 85 percent of the combined Old Age Security and Guaranteed Income Supplement. Extended care unit and intermediate care facility residents pay the same daily amount. Almost 40 percent of residents in for-profit facilities may also pay a superior room charge of approximately $3 to $9 per day.

The Ministry of Health provides a global budget to each free-standing extended care unit and calculates an implicit budget for an extended care unit attached to an acute care hospital. Budgets are again mostly based on staffing guidelines per resident per day. Since they do not share services with attached hospitals, free-standing extended care units receive more funds for non-care staff costs.

The Ministry of Health funds Continuing Care Division, Intermediate Care facilities and Hospital Programs Division extended care units differently. This dual system of reimbursement and funding methods creates a number of problems.

- If a facility invests resources in rehabilitation and a person becomes more mobile and requires less care, reimbursement — partly based on the number of residents at each care level — falls, acting as a disincentive to rehabilitate.
- Since Continuing Care Division facility staffing guidelines are maximums, an operator can cut staff to raise profits. Similarly, hospital management uninterested in long term care can deny resources to an attached extended care unit.
- Extended care units attached to acute care hospitals do not have separate reporting requirements.
- The Ministry of Health does not reward facilities for excellent care, nor does it reimburse them for assisting other facilities to improve their operations. Meanwhile, chronic bed shortages allow virtually any facility to fill its beds, which reduces the incentive for operators to compete on the basis of quality.

Quality can be rewarded only if it can be measured, but recent comparison shows that the Continuing Care Division's quality assurance standards are more vague than those of the Canadian Council on Health Facilities Accreditation.

- Care providers do not receive funding for staff education.
- Continuing Care guidelines are too general and do not adequately account for dementia-related behaviour.
- Some care providers in extended care units claim that staff levels – the basis for funding – are too low by as much as 30 percent, while some Continuing Care Division providers make the same claim for IC3 and EC staff levels. A number of submissions to the commission pointed to the need for social workers, occupational

therapists, physiotherapists and nurse specialists to handle complex cases, train staff, and oversee quality assurance.

The ministry recently funded more care staff and professional time for free-standing extended care units. It is also developing a workload measurement tool. However, the current system for classifying residents is out of date and needs to be revised so that there are more appropriate staffing levels.

Therefore, the commission recommends that:

12. the Ministry of Health, as part of the provincial health care personnel plan discussed in *Health Care Personnel*, review the current levels and mix of staffing in long term care facilities.

Private Long Term Care Services

In 1990, there were 2,600 licensed private personal care, intermediate care, and EC-level beds in BC. Most of these were at lower care levels. While currently small, the number of private facility residents is expected to rise as public financing for lower care facility beds declines.

Private facility residents currently include:

- people who have not met the one-year BC residency requirement for long term care
- Continuing Care Division clients and others on public facility waitlists
- disabled elderly with substantial resources who want superior accommodations and staffing.

In most private facilities, residents must transfer to a public facility when they reach the higher care levels.

The growth of the private sector raises a number of concerns.

- Construction is unregulated and some private facility designs are inappropriate for severely disabled people, tending to perpetuate the multi-level service problem.
- Private facilities are not monitored by *health unit assessors or Continuing Care Division quality assurance inspectors.
- The more affluent among those who want immediate long term care, but who cannot get it in the public system, will enter private facilities, while less affluent people will have to stay in the community. This raises concerns about the adequacy of community services.

With leadership and commitment, supportive housing could become a viable alternative to lower levels of facility care for those who are not affluent. This would be most successful if the staff of a home support agency or municipal health unit could provide services in the housing facility. The personnel could then take on some of the roles that regular staff play in care facilities, increasing the support for residents.

The Scandinavian countries have been very successful in developing supportive housing. And some projects in the United States, such as the On Lok Society in San Francisco, which combines supportive housing and a wide range of services, warrant a closer investigation.

There are also some excellent examples of supportive housing in this province. One particular model that impressed us was the Peace Lutheran facility in Fort St. John. Several small Abbeyfield homes are providing for seniors who need housing and a supportive environment. These are not within the federal/provincial Non-profit Housing Program Call for Submissions but have been assisted by the BC Housing Management Commission.

* GLOSSARY

Therefore, the commission recommends that:

13. **private long term care facilities be subject to the same quality monitoring process as public facilities.**
14. **supportive housing units be encouraged as a substitute for lower level facility care.**
15. **long term care services be delivered to supportive housing units.**

Several *submissions to the commission discuss problems with the administration of the facility wait list. Currently, clients who turn down the first available placement are faced with being sent to the bottom of the list, forcing them and their families to make quick, difficult decisions that are not always in their best interests.

Therefore, the commission recommends that:

16. **a person who is placed on the waiting list for admission to a long term care facility have the option to postpone accepting a placement without being moved to the bottom of the waiting list.**

PALLIATIVE CARE

You matter because you are you.
You matter to the last moment of your life,
and we will do all we can,
not only to help you die peacefully,
but also to live until you die.
Dame Cicely Saunders
(founder of the hospice movement)

Palliative care is:
- compassionate care for the dying person, directed towards comfort and support, rather than cure
- focussed on the needs of the individual and the family.

Palliative care should be:
- an option for people of all ages who are dying from any disease
- provided wherever and whenever the dying person chooses
- home-based whenever possible.

In communities throughout the province, the commission was told of the need for palliative care programs. Such requests reflect a deep concern that the last days of someone's life be as fulfilling and pain-free as possible.

We are impressed by the dedication of the volunteers who have given so much of their time to help establish and operate palliative care programs and we hope that they will continue in this work. While British Columbians can be proud of the programs which are in place, more can be done to provide palliative care.

This commission does not support the professionalization of dying. People are already dying; we want them to die comfortably.

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Client Population

There is very little information on the overall use of health services by palliative care patients. While these people account for 8.5 percent of the total provincial *home nursing and home support caseload, the total amount of nursing or support they use is not known. On average, cancer patients spend from one week to three months in a palliative care program, whereas people with AIDS may spend the last two years of their lives dependent upon the health care system, and the last few weeks or days dependent on a palliative care program.

Cancer patients make up 80 percent of the province's palliative care caseload. AIDS patients and others with terminal illnesses make up the remainder. Sixty-five percent of the people using the Vancouver Hospice program have cancer, 25 percent have AIDS, and 10 percent have other terminal illnesses.

CLIENT POPULATION

Cancer: In 1991, 13,000 British Columbians will be diagnosed with cancer. In 2001, this number will rise to 17,000, increasing the number of annual cancer deaths from 6,500 to 8,500. This increase will be mainly due to changing demographics.

AIDS: In 1991, some 6,000 BC residents are thought to be HIV+. Sixty percent of the total (957) AIDS cases identified since the first case in 1981, have now died. The number of new cases has stabilized at 200 - 250 a year. However, health officials in American cities report dramatic increases in HIV+ infection among people with multiple sexual partners, prostitutes, Native peoples, street people and injection drug users. Similar increases here in BC could seriously affect palliative care services.

Other terminal illnesses: These include amyotrophic lateral sclerosis (Lou Gehrig's disease), endstage cardiac and pulmonary diseases and renal failure. People dying from these causes seldom enter palliative care programs, therefore no comprehensive province-wide incidence figures are available.

In 1988, 48 percent of the province's terminal cancer and AIDS patients received some level of palliative care home nursing or home support. St Paul's Hospital's AIDS program has seen over 600 of the province's AIDS patients since 1982. In 1990, St. Paul's provided palliative care to 160 terminal phase AIDS patients, while the Vancouver Health Unit's community-based palliative care program provided care to about 90 AIDS patients.

Program Supply and Distribution

BC has 64 home or hospital-based palliative care programs. Home-based care is provided through *Home Care, community agencies, hospital outreach and voluntary groups. Hospital-based care includes multidisciplinary palliative care teams and beds on both general and palliative care wards.

Twenty programs (31%) based in the Greater Vancouver Regional Hospital District and the Capital Regional District receive the bulk of all palliative care funding. The remaining 44 programs (69%) are spread across 24 other regional hospital districts.

Program Access

A redistribution of resources from hospitals to the community, as described in ***Careful Spending***, would permit more people to die at home.

Palliative care programs are usually run by professionals in the province's cities, but outside of the major centres they are either run by volunteers or are non-existent. In smaller communities, palliative care home nursing or home support is dependent upon general home care nursing and home support services. Hospital-based palliative care is unreliable, as beds are not normally reserved for palliative care patients and it is difficult to ensure that they will be available when needed.

Dying at home may require the presence of healthy adult caregivers, extensive home care and home nursing support, visits by physicians, in-home drug therapy, and access to respite care. A 1986 study reported that approximately three-quarters of those patients who received home care died at home, whereas approximately 70 percent who did not receive home care died in hospital.

100 Mile House has converted an area in its hospital into a place where palliative care patients can die a comfortable death, in a caring environment complete with a door-knocking policy and some of the comforts of home. The Comox Valley hopes to establish a non-hospital-based free-standing hospice where hospital and other health care services can be brought in as they are needed. Examples like these are encouraging and deserve support. But communities must have access to clinical expertise in symptom management.

Therefore, the commission recommends that:

1. **each community have a palliative care program, preferably coordinated by the voluntary sector working in partnership with local hospital and home care programs. The program's components shall include**
   - **a. participation by all institutions;**
   - **b. uniform and consistent palliative care guidelines;**
   - **c. assured access to home nursing and home support;**
   - **d. immediate access to community hospital beds;**
   - **e. transfer of a portion of the existing budgets of hospital and home care programs to palliative care;**
   - **f. selection of a palliative care team from existing providers and volunteers; and**
   - **g. education of these providers and volunteers in palliative care treatment methods, ethics and philosophy.**

FUNDING FOR PALLIATIVE CARE

Funded Programs: In 1990 it cost approximately $7million to operate 64 palliative care programs in BC.

• $ 5,000,000	(71%):	Hospital palliative care in Vancouver, New Westminster or Victoria
• $ 1,200,000	(17%):	Home palliative nursing care through province-wide health units
• $ 309,000	(4%):	Hospital/Community Partnership palliative care pilot projects
• $ 286,000	(4%):	Volunteer programs
• $ 225,000	(3%):	City of Vancouver Health Unit's palliative care program

Unfunded Programs: Additional monies, in hospital global budgets, are being used to care for palliative care patients on general acute, extended or long term care facility wards.

The Need for Guidelines, Information and Education

The Ministry of Health has prepared and distributed a set of Operational Guidelines to help *long term care facilities develop policies on death and dying. We commend the Ministry for this initiative. We think that such guidelines should be required in *acute care institutions as well as long term care facilities. The ministry's objective is to establish a provincial standard of care.

The ministry's guidelines have been designed to apply specifically to long term care facilities. But while they are useful, they are not complete. In relation to palliative care, for example, there is no statement supporting the patient's or family's right to choose the type of care to be provided to the patient, including the patient's option of being admitted to a palliative care program.

The BC Hospice/Palliative Care Association has drafted standards for hospice and palliative care programs. These standards have yet to be approved by the membership, but they are more global and address more issues than the ministry's guidelines. Combining the best of both standards would appear to be the best idea.

It should be noted that the Project to Review Adult Guardianship is expected to make a number of recommendations about patient-appointed health proxies and living wills. Its recommendations should be carefully considered by the ministry and the Palliative Care Association.

It is clearly time for both organizations and government to come to grips with the nature of palliative care, its values, its requirements and its costs.
HOS-136

Therefore, the commission recommends that:

2. **the Ministry of Health work jointly with, and provide support to, the BC Hospice/ Palliative Care Association to complete standardized palliative care guidelines, and to complete a resource or training package. The guidelines should address**
   - **a. the mission of the palliative care program, and the goals and objectives surrounding the care of the terminally ill;**
   - **b. the equipment, medication and supplies that may be needed to assist patients who are dying;**
   - **c. effective pain management;**
   - **d. the psychological, spiritual and bereavement supports and other resources required to help palliative care patients and their families;**
   - **e. the education and training needs of staff and volunteers;**
   - **f. the patient's and family's right of choice to the specific types and levels of care, including the option of being admitted to a palliative care program;**
   - **g. the necessary relationships between hospitals, long term care facilities, home care and volunteers in the community in the treatment of the dying person;**
   - **h. the need to develop and implement a system to assess the quality of all facets of the palliative care program; and**
   - **i. the need to create a plan to implement the guidelines, delineating the responsibilities of all staff and volunteers, and designating who will be responsible for maintaining the guidelines and ensuring they are employed properly.**

Written Hospital Policies

Hospitals should be required to have written policies on the care of terminally ill patients. Such patients should have the option of choosing palliative care.

The written policy should include do-not-resuscitate orders, levels of pain medication, and so forth. We say this because most of the inappropriate treatment of dying patients takes place in hospitals where the nature of hospital care requires that people adhere to established procedures.

Therefore, the commission recommends that:

3. every hospital should have a written policy distributed to staff and patients on the care of terminally ill patients.

Medication and Symptom Management

The medication issues heard by the commission focus on the quality of care for palliative care patients and the cost of providing that care. It was pointed out to us a number of times that the province's current funding arrangements encourage people to receive care in a facility rather than at home.

Funding of Prescription Drugs. While palliative care patients in acute care or long term care facilities do not pay for prescription drugs, people at home pay up to $2,000 per family, except seniors who pay up to $125 each. People claiming a rebate from Pharmacare have to pay the total cost at the time of dispensing, then wait up to three months for reimbursement.

Funding of uninsured supplies and non-prescription drugs. Pharmacare does not provide for all of the supplies and non-prescription drugs needed by palliative care patients. For example, bowel regimen supplies, walkers, commodes, and pain pumps are not covered by the provincial Pharmacare plans but are provided in acute care and long term care facilities. There is partial funding under Pharmacare for the reusable pain pump, a particularly expensive item used to deliver a continual supply of medication, but it is only for the medication used in the pump, and does not pay for the pump itself ($1800-$4000), nor for the cassette used to deliver the drug ($900-$1500/year).

The medications are horribly expensive, and one of the reasons the patient is kept in the hospital is one, for the IV therapy, and two, because of the cost of the medication.
HOS-080

Administration of intravenous drugs by home care nurses. Some patients receive intravenous (IV) drug therapy at home through the Capital Regional District, and through the Hospital Community Partnership Program projects in Vancouver. In most parts of the province, however, people needing IV drugs must be admitted to hospital. Nurses working out of health units do not provide IV drugs to patients in the home.

Therefore, the commission recommends that:

4. drugs, supplies, equipment and services necessary for the care of palliative care patients in the home be provided at no cost to the patient.

C-178

THE RIGHT TO DIE WITH DIGNITY

In the last 18 months the commission has heard a great deal about the importance of death with dignity. People expressed concern about the use of do-not-resuscitate and degree-of-intervention orders. Support was voiced for living wills as a way to allow people to die with dignity. These concerns were underscored by the growing need for more and better *palliative care programs, which is addressed in ***Palliative Care.*** Living wills and the patient's right to appoint a health proxy are currently being dealt with by the Guardianship Committee.

The commission approves the widespread support for the notion of the right to die with dignity. However, what is meant by *dignity* varies from person to person and the issue of euthanasia raises many concerns, particularly over the appropriateness of so-called "mercy killing".

The principle which has guided us in our deliberations is that, wherever possible, the person who is dying should have the right to determine the form and time of death. Respecting this will help ensure a dignified death.

"There is no way to practice death, but we can plan for dignity."
HOS-136

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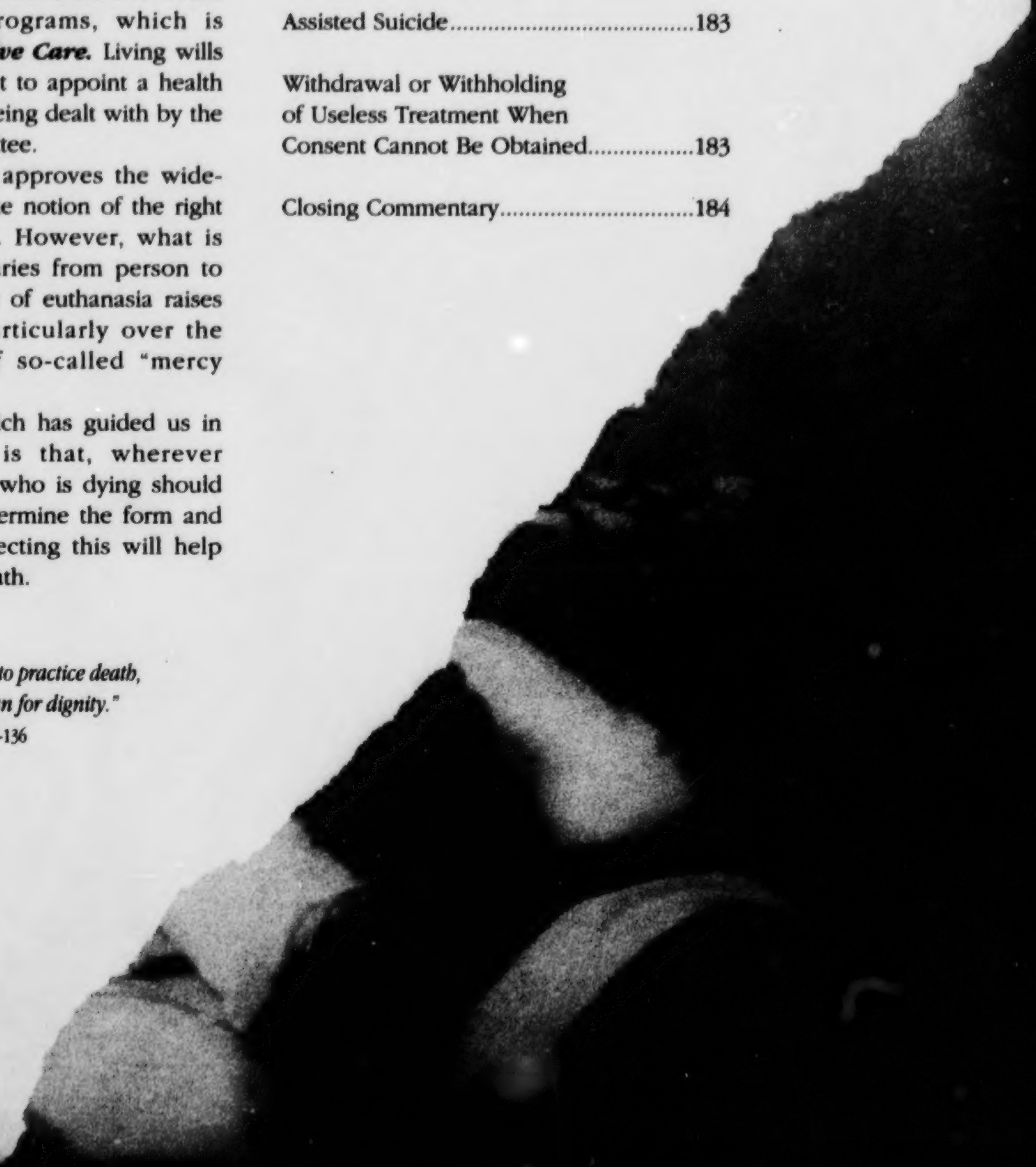

Peggy's Story

Last year, early in the morning, a code was called on the third floor.
By the time I arrived with the crash cart, CPR was in progress and a nurse
was starting an IV. On the bed was a thin little old lady, and I heard a couple
of cracking ribs as someone pushed down for cardiac compressions.
Our routine is well rehearsed... Cardiac monitor shows ventricular fibrillation.
No pulse. Defibrillate. No change. Give IV medication, continue CPR.
Since she was so little, I used a small adult dose of electricity for defibrillation.
Still no response. I felt sick. I asked, "How old is this lady?".
She was ninety-four. "What are we doing?" Everyone else looked sick.
"We have no choice Peggy, she is not a 'no code.' She's not sick.
She's here for respite care while her family is out of town." A doctor arrived,
learned the age of the patient and asked again, "What are you doing?"
I felt as though I had committed a profound, unforgivable sin.
HCP-002

The conditions of treatment of a dying patient may be characterized in three ways:

- the manner in which the treatment is performed
- the value to the patient of the treatment
- the nature of the consent given or withheld.

Treatment may be applied, withdrawn or withheld.

Applied treatment is when a health care provider does something directly to the patient in an active and direct fashion knowing that such treatment may result in the patient's death, e.g., injecting a dose of a medication that might be fatal.

Withdrawn treatment is when a treatment which has already been applied is later withdrawn by a care provider knowing that death is likely to ensue as a result of "nature taking its course," e.g., turning off a respirator.

Withheld treatment is when treatment is not initiated by the care provider knowing that death is likely to ensue as a result of "nature taking its course," e.g., if there is a do-not-resuscitate order on the patient's chart and the patient experiences a cardiac arrest, the health care provider will not initiate cardiopulmonary resuscitation to save the patient.

The types of treatment which may be applied, withdrawn or withheld can be placed into two general categories, based upon the nature of their consequences. The distinction between these two is based on the benefit to patients in their particular situations.

Therapeutically useful treatment is treatment that is intended to provide reasonable benefit for the patient.

Therapeutically useless treatment is treatment that cannot provide a reasonable benefit to the patient, or that causes pain or other negative consequences which outweigh the benefit. For terminally ill patients or patients in a persistent vegetative state, therapeutically useless treatment simply prolongs or sustains life without offering any reasonable hope of improvement in their condition.

The form of the particular treatment is of little consequence when distinguishing between therapeutically useful and therapeutically useless treatment. In this respect, the distinction between *ordinary* and *extraordinary* treatment offered by some writers does not seem particularly useful. ***The key question is whether or not a specific treatment will provide some benefit to a particular patient in that patient's unique circumstances.***

For example, dialysis would be therapeutically useful treatment for an otherwise healthy patient with kidney disease; it would undoubtedly save that patient's life. However, dialysis may be therapeutically useless treatment for a terminally ill patient who is experiencing great pain and is about to die of a cancer which has the secondary effect of causing end-stage renal failure. Dialysis may even cause that patient greater pain and suffering.

Before treatment is offered, withdrawn or withheld, it is important in most circumstances that the patient or legal proxy gives consent. Consent to medical treatment must be given freely and without coercion, and only after the patient or proxy has been fully and adequately informed as to the consequences of the treatment or the refusal of treatment.

Voluntary treatment is when treatment has been undertaken after the patient has given full and proper consent to that treatment.

Involuntary treatment is treatment that is applied, or withdrawn against the patient's wishes.

Non-voluntary treatment is treatment undertaken when consent cannot be given as, for example, when the patient is in a persistent vegetative state and a legal proxy does not exist or cannot be located.

Non-voluntary treatment is not the same as *involuntary treatment*. The former focuses on the patient's inability to give consent; the latter focuses on not following the patient's wishes.

The Right to Die with Dignity

The right to refuse treatment can be seen as the ultimate expression of the right to die with dignity, because it is based upon the right to be informed and the right to direct treatment. These rights direct health care workers to inform the patient of the treatment being proposed and to obtain the *informed consent of that patient before treatment is initiated. If treatment is undertaken without consent, a *battery* occurs, and the physician or other health care worker may be subject to criminal charges or civil liability. If the information provided is insufficient for the patient to make an informed decision, then consent is not properly given and a legal action could arise. Health care workers who act against a patient's wishes may face civil or criminal liability, so long as the patient's wishes are legally binding on the provider and are sufficiently specific to address the particular situation.

In its 1982 working paper, the Law Reform Commission of Canada (LRC) did not resolve the issue of whether a patient should always have the right to refuse any treatment offered or to request that any treatment initiated be withdrawn. Nonetheless, the LRC recommended that the Criminal Code be amended to give formal recognition to the competent patient's absolute right to refuse medical treatment or to demand its cessation. To date, the federal Parliament has not acted upon that recommendation.

Therefore, the commission recommends that:

1. **the provincial government request that the federal government amend the Criminal Code to recognize the competent adult patient's absolute right to refuse medical treatment or demand its cessation, and that where the person is not competent, the right may be exercised by a duly appointed proxy.**

Requested Mercy Killing

It's very hard
as a nurse
to look after somebody
who is pleading to die,
and yet the system
won't let them do it,
and we utilize
all kinds of treatments
and technologies,
and we're the ones
that sit
and hold their hands
while they cry.
HOS-021

Many people feel that some form of mercy killing should be permitted when the patient requests that life be ended. There is no right to this form of euthanasia under existing law, because no one has a corresponding legal duty to kill a patient, even if requested to do so.

Despite the general prohibition against mercy killing, the common law provides a defence to a physician who administers medication to a terminally ill patient under certain circumstances, even if that physician knows that eventually he or she may administer a fatal dose. A Canadian court would probably conclude that the physician acted within the law if:

- the drug was necessary to combat the patient's pain
- the physician regarded the risk of a fatal dose as unavoidable, but nonetheless warranted, because the patient's suffering could not otherwise be relieved
- the physician gave the fatal dose for the purpose of relieving pain and not for the purpose of killing the patient.

In 1982, the LRC recommended that mercy killings not be directly sanctioned by law. It specifically rejected proposals to bring about legal changes that would authorize a terminally ill person to request a quick and painless death. However, the LRC did recommend – and this commission agrees – that the Criminal Code be amended to permit a physician to administer pain control medication to a terminally ill patient, even if that has the secondary effect of shortening the life of that patient.

Therefore, the commission recommends that:

2. **the provincial government request that the federal government amend the Criminal Code to make clear that if a terminally ill patient's suffering cannot be otherwise relieved, a physician may prescribe, and a health care worker may administer, any therapeutically necessary pain relief medication to that patient in a dose which may be fatal.**

When a person is dying, the health care system can offer that patient a great deal of support and care, and, if requested, can perform many valuable services. However, if the same patient wishes to die, the health care system is not capable of responding and there is no one who can assist the dying patient in deciding the time and manner of death.

In Holland, the courts have permitted active voluntary euthanasia to occur, but only where medically justified and under the guidance of the Royal Dutch Medical Association. The Association has issued guidelines to make the practice clearer and ensure it is in keeping with Dutch law. The guidelines contain seven elements:

- the patient must repeatedly and explicitly express the desire to die
- the patient's decision must be well-informed, free and enduring
- the patient must be suffering from severe physical or mental pain with no prospect of relief
- all other options for care must have been exhausted or refused by the patient
- euthanasia must be carried out by a qualified physician
- the physician must consult at least one other physician, and
- the physician must inform the local coroner that euthanasia has occurred.

If a physician does not wish to comply with the request, a colleague must be found who is willing to do so.

Despite these guidelines, active voluntary euthanasia still has an ambiguous legal status in Holland. There is no legislation which legalizes the practice. Prosecutors still have full discretion to press charges and this apparently discourages some physicians. There have been calls to formally legalize the practice, rather than rely upon the guidelines.

Active voluntary euthanasia was the subject of considerable debate among the commissioners. Several commissioners do not accept the idea that a physician should be allowed to kill people in as direct a fashion as is permitted in Holland. They feel that endorsing this position would create a confusion of legal and practical problems. Others accept the Dutch guidelines and feel that terminally ill patients have an absolute right to determine the time and mode of death. They believe that health care workers should be protected from criminal charges if they assist terminally ill patients in ending their lives. In the end, a consensus could not be reached.

Assisted Suicide

It is no longer illegal for someone to commit or attempt to commit suicide. However, under section 241 of the Criminal Code, it is still a criminal offence for someone to counsel or aid someone who either attempts or commits suicide. If convicted, the person who assists could go to prison for up to 14 years. All of the commissioners agree that there is a right to commit suicide, and that, under appropriate circumstances, a physician should be allowed to assist a person who chooses to exercise that right.

Therefore, the commission recommends that:

3. **the provincial government request that the federal government amend section 241 (b) of the Criminal Code so that it does not apply where the person who commits or attempts to commit suicide is terminally ill, and where a health care worker who helps that person to commit or attempt to commit suicide does so in accordance with the ethical standards of his or her profession.**

Withdrawal or Withholding of Useless Treatment When Consent Cannot Be Obtained

The commission received a number of *submissions on the issue of withdrawing or withholding useless treatment when consent cannot be obtained. It is clear that most people think that being kept alive by artificial means with no possibility of recovery, while, at the same time, being unable to consent to treatment or to request the withdrawal of treatment, is unacceptable.

For a number of years, the American courts have ruled that life-prolonging and therapeutically-useless treatment can be withheld or withdrawn from patients, such as those in irreversible comas, who are not capable of making their own decisions. Little attention has been given in Canadian courts to similar situations and Canadian law is not clear on whether a physician may disconnect life support systems or write do-not-resuscitate orders for incapable patients. Canadian doctors, however, appear to act as if American jurisprudence and legislation apply north of the border.

Our society has been set up in such a way that death is almost like a failure. It's like something's gone wrong when you die. Rather than that it's a part of our life.
HOS-122

* GLOSSARY

The role of the family or a close friend in making decisions for patients who are not capable is also in question.

Approximately one-half of the patients who die while receiving palliative care are incapable of giving consent to the withdrawal of medical treatment. Physicians commonly withdraw or withhold treatment either after discussing the situation with family members or, where no family can be located, with a friend of the patient or with a colleague. While physicians often rely upon such discussions, unless the relative or friend has been appointed as the patient's legal guardian, the physician is not protected from criminal or civil liability. While a physician may feel ethically obliged to consult and take directions from the family or friend, by default the community has delegated to the physician the power and the responsibility to decide whether to continue treatment and whether the patient, if competent, would have preferred to be kept alive. This situation casts an onerous duty upon the physician.

We cannot expect, even with the best health care to live forever, and any system that we have is going to have to allow us to live with dignity as well as to die with dignity.
MUN-020

A physician is not under legal obligation to provide therapeutically useless treatment to a patient and would not likely be charged for withholding or withdrawing such treatment. Admittedly, it may not always be easy to determine whether a particular treatment is useful or useless. But, on the assumption that such a distinction can be made, the physician should be able to withdraw or withhold that treatment in appropriate circumstances without fear of criminal or civil charges.

Therefore, the commission recommends that:

4. **the provincial government enact legislation and request that the federal government amend the Criminal Code so that a physician may withdraw or withhold treatment where**
    - **a. a patient is terminally ill or exists in a persistent vegetative state, no longer enjoys any quality of life, and cannot give or withhold consent;**
    - **b. the physician is of the opinion that the treatment is therapeutically useless; and**
    - **c. a proxy to give consent to the withholding or withdrawal of such treatment cannot be identified readily or has not been appointed by the courts or the patient.**

Closing Commentary

In studying the right to die with dignity, the commission was impressed by what people said in their written briefs and during the public hearings. There can be no doubt that the public is concerned about death with dignity.

The commission studied a number of reports, including the Law Reform Commission's 1982 working paper *Euthanasia, Aiding Suicide and Cessation of Treatment*. In that paper, the LRC determined that no Canadian physician had been convicted of shortening the life of a terminally ill patient by administering massive doses of painkilling drugs, or convicted for stopping medically useless treatment for a dying patient. However, the LRC went on to conclude that there is no certainty that Canadian courts would always acquit physicians involved in such situations.

The LRC felt the existing legal situation could not be considered satisfactory solely because it had not given rise to legal proceedings. It concluded that many health care workers either do not know the precise content of their legal duties or wish to be dependent upon the Crown's discretion not to press charges. The law's silence appears to have been interpreted by Canadian health care workers as a true endorsement of current medical practice.

There is commentary throughout the LRC's paper on the legal uncertainty which health care workers face when trying to assist patients who are dying or want to die. In pressing for legal predictability and certainty, and objectivity and uniformity in medical practice, the LRC set out a series of recommendations. This commission supports the general principles behind the LRC's recommendations. However, we also recognize the need for further research because of the recommendations' profound implications.

It appears that the LRC did not do comprehensive research or survey Canadian physicians or hospitals to determine the prevalence of the various practices, nor did it thoroughly investigate the likelihood that the provincial Attorneys General would always decline to initiate criminal charges in the circumstances described. The LRC's analysis appears to be based entirely on a review of the reported cases and a consideration of what various scholars have said about the subject. Therefore, it could be concluded that one reason the federal government has not acted upon the LRC's recommendations is because it does not yet have proof that the problems described in fact exist or exist to the extent that would justify the amendments to the Criminal Code recommended by the LRC.

In March 1991, the federal minister of justice announced in Parliament that her ministry would undertake a study of the issue of euthanasia. If the federal government studies this subject, in addition to undertaking an analysis of the law, we believe it would be useful for it to undertake a thorough and scientific survey of the current practices regarding cessation or refusal of treatment, euthanasia, aiding and abetting suicide, and related issues.

PART D: PERSONNEL

The sixty thousand people employed in the delivery of health care services in this province represent an immense provincial resource which must be properly organized to provide the best care possible to the greatest number of people possible.

> *Although we have been ever mindful*
> *of the present constitutional provisions*
> *respecting jurisdiction over health matters,*
> *we cannot ignore the unequal distribution*
> *of resources, particularly of personnel,*
> *to meet our health needs.*

Royal Commission on Health Services, 1964. Vol.1.

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HEALTH CARE PERSONNEL

There are four sections to this chapter: *Physicians*, *Nurses*, *Allied Health Care Workers*, and *Midwives*. Each section is built upon a central theme: ***personnel planning for health care workers in British Columbia must be based upon carefully identified needs***.

This is not a new idea. In his 1973 report, *Health Security for British Columbians*, Dr. Richard Foulkes recommended that personnel studies be promptly undertaken. He also recommended that the Ministry of Health and the province's educational institutions stop the creation of new categories of health care workers until after there had been a careful assessment of the health care needs of the province. This commission strongly endorses Dr. Foulkes' recommendations. We are concerned that, 18 years later, there is no provincial health care personnel plan and that the province has failed to tie training to clearly identified needs.

Therefore, the commission recommends that:

1. **the Ministry of Health make a detailed assessment of health care personnel requirements in the province and publish a provincial health care personnel plan based on identifiable needs. The plan shall**
   a. **include specific directions for implementation; and**
   b. **be updated and published periodically.**
2. **funds for educational institutions be used to ensure that training opportunities are related to the provincial health care personnel plan.**

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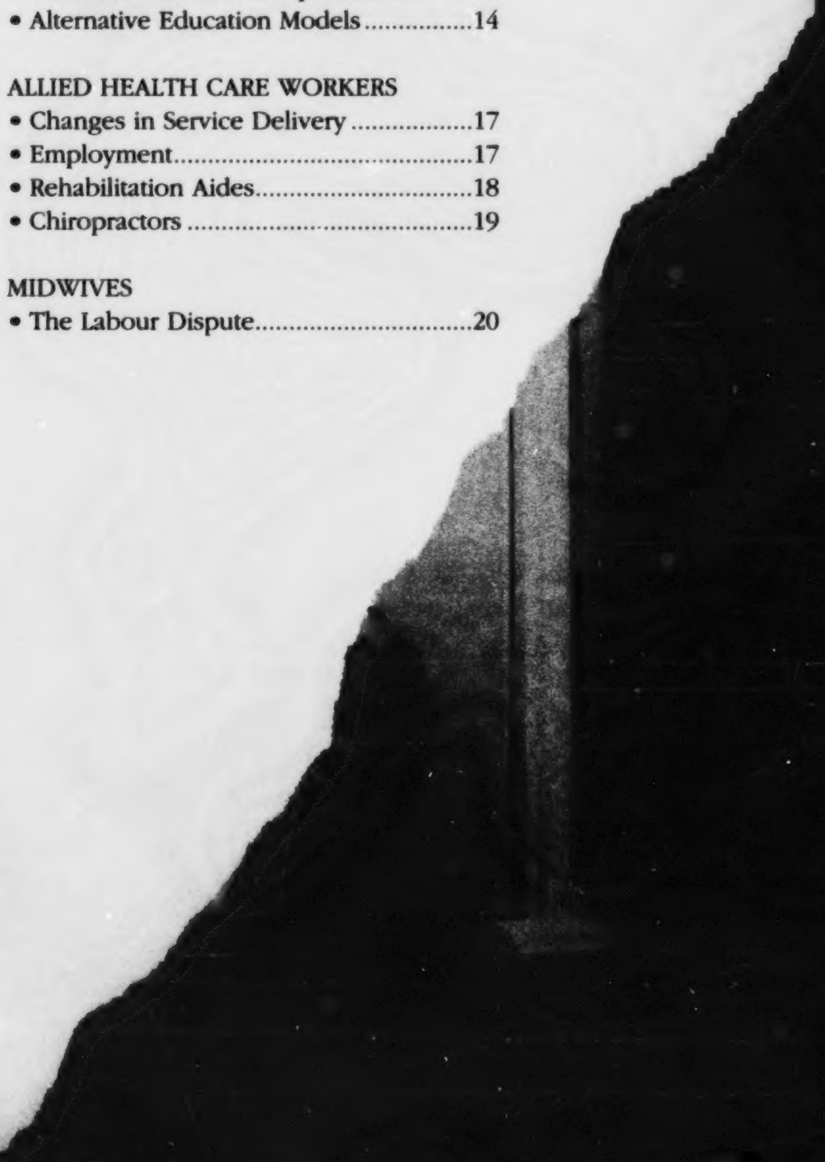
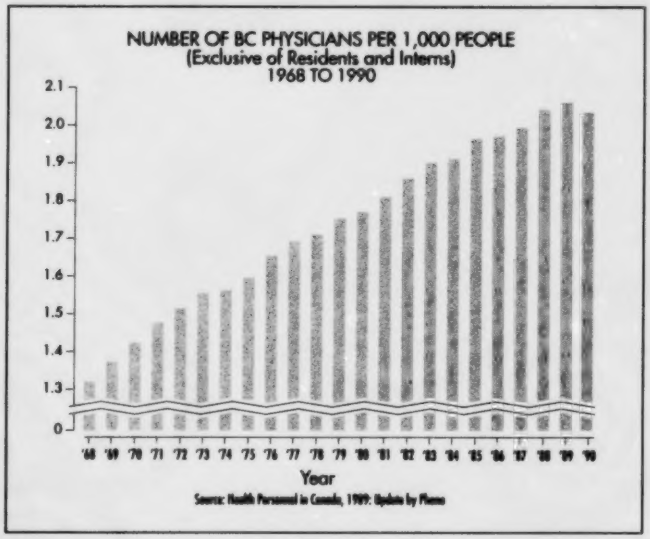


PHYSICIANS

• *The Supply of Physicians*

The current formulas for calculating the necessary supply of physicians for any given area are based on Medical Services Plan (MSP) expenditures, the rates of use of physicians' services in a base year, and expected changes in the population.

They are inaccurate. Among other things, they assume that all of the services billed by physicians in the base year were necessary, that there are no changes in the relative roles of health care workers over time, and that special interest groups are unable to influence the health care system.


NUMBER OF BC PHYSICIANS PER 1,000 PEOPLE
(Exclusive of Residents and Interns)
1968 TO 1990

Source: Health Personnel in Canada, 1989; Update by [illegible]

A University of Alberta study covering a 4 year period, 1983 to '87, showed a numerically stable population, a 20% increase in the number of licensed physicians, and a 38.4% increase in doctors' billings to the government health insurance plan.
SOC-204

Errors in estimating population growth, discussed in ***Careful Spending*** contributed directly to the prediction by The Royal Commission on Health Services (Hall Report, 1964) that there would be a physician shortage, and the recommendation of an expansion of Canada's medical schools. But the supply of physicians in Canada is now increasing at a greater rate than that of the population. And there is reason to think that this increase is associated with the current increase in the use and cost of health care services.

The western Canadian provinces have a physician to population ratio of about 1:550. In British Columbia, though, the ratio is less than 1:500. Although there are too many doctors in some geographic areas – such as Victoria and parts of the Okanagan – and shortages in other areas and in some specialties, the commission concludes that the province has enough physicians. What the province needs to do is redistribute them.

To correctly match the number of physicians to the provincial need, a health care personnel plan must focus on aggregated or group characteristics. The variables used in this analysis should be:

- provincial health policies
- the number of training positions in the province
- inter-provincial migration
- immigration policy
- death, retirement and other reasons for physician loss.

The plan must also include:

- the age profile of the population
- the ability of a health care system to affect the population's health
- the nature and extent of the available resources
- change in clinical practice
- change in health care priorities (for example, from institutional care to *community care)
- the relationship between the number of physicians and health care expenditures
- the effect of substituting other appropriately trained health care workers for physicians.

The relationships between these variables are important to the effective and efficient delivery of services, for example, policy decisions about how training of physicians affects the whole structure of health care, particularly *tertiary hospitals where the cost of treatment is influenced by education policies that involve residents and training slots. The technology available in these high-tech teaching environments also has a long-term influence on the skills and knowledge of medical students as well as the design of education programs and the geographic distribution of physicians. Currently, though, there are no clear objectives for medical education in this province and the government disburses its funds without first considering provincial health care needs.

MSP payments could be used to influence medical school activity. To do this, the Ministry of Health must work with the UBC Faculty of Medicine to:

- shift educational programs to a community focus
- fund sessions in community clinics
- provide support for practitioners in rural communities.

We recognize that the majority of physicians practicing in BC were not trained here, and that a national agreement combining medical school enrolments with carefully identified health care needs is essential if the physician to population ratio is to be controlled. In addition, the Ministry of Health will have to ensure that residencies funded by agencies other than the provincial government meet the needs set out in the health care personnel plan.

We are also concerned that medical residents sometimes occupy positions to meet the service needs of institutions rather than to receive training. This practice can contribute to an oversupply of certain specialties, and these positions should be filled by other appropriately trained personnel.

The commission has reviewed the exhaustive report, *Toward Integrated Medical Resource Policies for Canada*, recently completed for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health. We agree with its analysis and believe that its recommendations are consistent with ours.

Therefore, the commission recommends that:

3. the government of BC
  a. negotiate with other provinces to set appropriate levels for medical school enrollment based on demographics and identified needs;
  b. ensure that post graduate training is consistent with the provincial health care personnel plan, and not establish or continue residencies except for the purpose of training needed personnel; and
  c. not permit the creation of residency positions by agencies other than government to distort the provincial health care personnel plan.

Foreign trained physicians also add to the growing supply of physicians in Canada. Over the last decade, an average of 400 immigrants each year indicate medicine as their intended occupation (445 in 1990). This is nearly a quarter of the total graduates of Canadian medical schools. But this does not include those immigrants who do not declare their intentions. In addition, not all foreign medical graduates are immigrants; some Canadian citizens go abroad for training.

In 1984, a report of the Federal/Provincial Advisory Committee on Health Human Resources recommended major reductions in the numbers of immigrants permitted to enter medical practice in Canada. But the number of foreign trained physicians specifically recruited ("selected") to Canada did not fall until 1988 (from 144 to 92), and this has been more than offset by increases in the number of relative-sponsored and refugee physicians.

In 1989, there were 7,621 post-MD training positions available in Canada, 1,402 (18.3%) of which were filled by graduates of foreign medical schools. Ninety percent of the graduates of foreign medical schools were training in a specialty and consisted of approximately:

- 55 percent visa trainees (an employment visa is granted with the expectation that the trainees will return to their homelands)
- 29 percent landed immigrants
- 16 percent Canadian citizens who had received their MDs outside of Canada.

It has been estimated that at least 25 percent of the physicians on employment visas are successful in gaining licensure and staying in Canada, a trend which may be encouraged by recent Employment and Immigration Canada regulations. These regulations allow foreign graduates to live in Canada upon graduation for education-related employment in a location of their choice for one year.

Foreign graduates not only increase the supply of physicians, but they also put pressure on government to provide training and licensing opportunities.

Legislation must be enacted which removes the ability of pressure groups to demand training for foreign-educated physicians. At the same time, the province must recognize the special health care needs of some of BC's ethnic populations.

When you're
in lotus land
everyone wants
to come here.
The more doctors
you have
the more patients
you have.
IND-213

Therefore, the commission recommends that:

4. the Ministry of Health
   - **a. clearly state that immigrant physicians do not have a right to practice in BC;**
   - **b. limit positions for graduates of foreign medical schools to those necessary to meet the health care needs of BC, taking into account the special needs of multicultural populations;**
   - **c. develop ways to encourage Canadian graduates to prepare to practice in fields where shortages prevail;**
   - **d. create a central recruiting office within the ministry which may use private agencies, and will be responsible for filling difficult-to-fill positions, giving priority to Canadian citizens and landed immigrants; and**
   - **e. require visa trainees to sign an agreement not to stay in Canada as a term of their educational license, and the agreement be enforced.**

In 1983, the government of the day introduced a bill that would limit the number of physicians permitted to bill MSP. Although the bill did not pass, the scheme was implemented by the Medical Services Commission. It was then challenged in the courts and set aside as not authorized under the existing legislation.

In 1985, legislation to this effect was introduced and passed. It was also challenged in court, but this time it was upheld. This decision then went to the BC Court of Appeal, which concluded that the legislation was inconsistent with the Canadian Charter of Rights and Freedoms and overturned the lower court's decision.

For our health care system to survive and, indeed, for the benefit of physicians as well, the government and the British Columbia Medical Association (BCMA) must work together to ensure that there are an appropriate number of physicians and no more.

Therefore, the commission recommends that:

5. the Ministry of Health and the BC Medical Association give priority to the joint development of a program to limit the number of physicians.

Once again, we emphasize the essential requirement that ***health care personnel planning for BC must be based upon carefully identified needs***.

•*Compensation for Physicians*

The supply of physicians, their distribution and their patterns of practice affect the quality, financing and organization of health care. In part, physicians are gatekeepers on the path of patient care and they control the demand for services. They do this because of their concern for their patients, their training, and the *fee-for-service schedule, all of which tend to point them to increased patient contact and to providing certain interventions more than others.

Sixty per cent of all MSP payments go to specialists, many of whom, such as anaesthetists and radiologists, work in hospitals. Despite this, the province's current policies do not encourage salaried positions rather than fee-for-service for hospital-based specialists, nor do they encourage contractual relationships between specialists and community-based clinics. This contributes to the shortage of physicians in remote and rural areas. As we have stated in a number of places in this report, the government needs to do more to support community-based clinics and contractual arrangements.

Therefore, the commission recommends that:

6. the Ministry of Health
   a. shift away from fee-for-service toward salaried positions for hospital-based specialists and toward contractual relationships between specialists and community-based clinics; and
   b. encourage funding for community-based clinics which employ salaried general practitioners and may have direct links with either specialists on salary with hospitals or specialists on contract to community-based clinics.

Currently, the province pays a decreasing portion of physicians' fees if total payments to physicians are more than a specific amount. Some provinces also provide separate limits for specialists and family practitioners, as well as income limits for each practitioner. All of these devices can be used in correcting poor geographical distribution. However, we feel that capping the incomes of individuals is unnecessary. The majority of physicians with high incomes achieve them by working very hard or having some unique skill. If some of their colleagues abuse the system, then that is a matter for the Patterns of Practice Committee to deal with.

Therefore, the commission recommends that:

7. **the BC Medical Association and the Ministry of Health limit expenditures on physician services by**
    - a. **imposing an annual global cap on total gross payments to physicians;**
    - b. **applying an appropriate cap on the total amount paid for physician services in specific regions; and**
    - c. **defining within the cap the total amount paid for general practice in each region, and the total amount paid for each category of specialty in each region.**

These regional and specialty caps are to apply to the payments on behalf of residents of each region, rather than to the payments to the practitioner located in the region. As pointed out in ***Health Care Services in Remote and Rural Areas of BC***, the shortage of physicians in certain specialties and regions of the province limits access to physician services, nursing care and *acute care. It also affects employment in rural and remote communities by reducing their ability to attract other professionals, businesses and industries.

> *At the request of either party,*
> *but no later than*
> *September 30*
> *in any fiscal year*
> *prior to the expiry of a*
> *Working Agreement,*
> *the parties will meet to review the payment schedule*
> *and*
> *the total claims cost experience.*
> Memorandum of Agreement

Therefore, the commission recommends that:

8. **salary options be improved for physicians who practice in rural and remote regions by enhanced fringe benefit packages and flexible scheduling.**
9. **quality of life be improved for physicians who practice in rural and remote regions by providing professional and technical support as well as temporary replacements through a provincial pool, subsidized travel, isolation allowances and opportunities for continuing education.**
10. **where appropriate, in small communities, offices in existing medical facilities be rented to physicians at cost.**

• *The Fee Schedule*

The commission has heard a number of criticisms of the fee-for-service schedule, most of them from individual physicians. For example, we heard that the fee schedule does not adequately compensate rural general practitioners for a number of services, including looking after critically ill patients, performing surgery, or administering anaesthetics. The BCMA recognizes that certain parts of the fee schedule must be changed and it has established a "relative value" committee to redesign the schedule to reflect the judgment and skills required for specific services.

By paying physicians more for certain procedures than for others, the fee schedule encourages medical interventions with the highest financial return rather than those with the best outcomes. But while we favour a gradual reduction in the number of fee-for-service physicians, we also recognize that fee-for-service will continue to play a significant role in providing medical services. The fee schedule could even prove to be a useful tool for public policy, substantially altering the distribution of physicians within the province and among specialties. To achieve this, the fee-for-service schedule must be redesigned. And we think that it is inappropriate for that to happen without substantial input from the public.

Fee negotiations between the BCMA and the provincial government are governed by a Master Agreement and the current agreement is set out in a Memorandum of Agreement dated December 27, 1990. In previous years the government has asked the BCMA to outline its requests in a comprehensive list, then the government has responded with its own offer. At no time are the negotiations between the BCMA and the government open to public scrutiny.

As explained in ***Labour Relations***, compulsory arbitration, contrary to the opinion of the BCMA, is not a solution to deadlocked or unsuccessful negotiations. The fee schedule is much too complex and important to the survival of our health care system to be considered in the heat of urgent negotiations, during compulsory arbitration, or behind closed doors. Instead, there should be an independent, credible body which can assess the circumstances, report to the parties and the public, and encourage responsible and effective bargaining by both sides.

Therefore, the commission recommends that:

11. the Ministry of Health and BC Medical Association establish a permanent independent five member board, with a small staff, to

- **a. provide public scrutiny;**
- **b. continually monitor the structure and relative value of various items in the fee schedule and its effect upon the provision of medical services in the province;**
- **c. recommend changes, and**
- **d. publish an annual report.**

12. the five member board should be composed of two members appointed by the BCMA, two members appointed by the ministry, and an independent chairperson chosen by the four; all to have security of tenure, with terms to be staggered and a minimum of three years' notice for dissolution.

• *Physician Involvement in Planning and Management*

Physicians have a valuable perspective on health care and it is essential that they participate in planning and management. Many physicians, however, complain that they are not paid to manage, while others argue that management duties are a professional responsibility. The commission generally accepts the latter view and notes that physicians receive a number of benefits, other than fee-for-service, which might be considered, in part, compensation for such tasks.

In the agreement that covers the three years up to March 1992, the government will contribute $30 million to the BCMA for liability insurance, $17.5 million for disability income and $18.9 million for educational courses and conferences. In addition to this $66.4 million, the government has agreed to pay $25 million each year for a pension plan. This is in addition to MSP payments and is not tied to any specific service rendered by physicians.

Physicians may recognize that they have a contractual duty to the public to participate on committees and manage certain programs in return for the privilege of using public resources. Nevertheless, for onerous, time-consuming management duties, payment is appropriate.

At present, physicians participating in the planning and management of hospital programs are paid on either a sessional basis (a flat rate for a set period of time) by the Medical Services Commission, or through the operational budgets of hospitals, if they are paid at all. However, the Medical Services Commission is very selective in approving sessional fees for this purpose, and hospitals do not typically set aside much money to pay physicians for management duties.

Therefore, the commission recommends that:

13. hospital boards encourage physicians to be involved in managing the hospital system, and that
  - **a. physicians be paid for their participation through the operational budgets of the hospital;**
  - **b. hospitals, in consultation with physicians, decide upon an appropriate amount of money to be allocated to these functions; and**
  - **c. MSP deduct this amount from the billing of all the physicians with admitting privileges to the hospital and remit it to the hospital. The amount should not be included in the hospital's *global budget allocation by Hospital Programs.**

•*The BCMA*

We think that a strong voice for physicians, particularly in collective bargaining, serves the interests of all British Columbians. Currently, the BCMA negotiates on behalf of physicians in the province, but membership in the association is not compulsory.

This means that there is continual pressure to ensure that particular groups of physicians currently favoured by the fee schedule do not become disenchanted and withdraw from the association. This weakens the BCMA's ability to negotiate and make bold decisions.

Therefore, the commission recommends that:

14. membership in the BC Medical Association not be compulsory, but that all physicians practicing in the province be required to remit dues to the association and be bound by the collective agreement (Rand Formula).

NURSES
•Efficient Deployment

Health care is labour intensive and the recruitment, deployment, retention and compensation of nurses are issues vital to successfully implementing a provincial health care personnel plan.

Currently, there are no comprehensive data or even a simple descriptive account of the supply of nurses in the province. As a result, nursing vacancies, particularly difficult-to-fill vacancies, are often used to indicate nursing shortages.

But ***nursing vacancies are not an appropriate measure of shortages***. They occur for a number of reasons, including inefficient deployment of nurses, and they only describe empty positions. They are not a substitute for the accurate measurement of patient needs or the capacity and nature of professional practice.

Three types of nurses are employed in BC: Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs). Nurse to population studies show that the number of RNs relative to the population is higher than that of LPNs in all areas of service. RNs dominate in critical care and medical-surgical specialties, administration and teaching. According to several studies, RNs are more likely to remain in practice and less likely to let their professional affiliations lapse when they leave the workforce. RNs are also the only nurses that are self-employed although this is very rare.

RNs, LPNs and RPNs are each divided into three categories for the purposes of health care planning.

Full-time staff: an employee regularly scheduled to work 7.5 hours per day or 37.5 hours per week, adjusted frequently to accommodate a 12 hour shift schedule.

Part-time staff: an employee regularly scheduled to work a minimum of 15 hours per week.

Casual staff: an employee that works full or part time on an on-call basis.

Hospitals often have to rely on nurses trained outside the province and cannot predict the composition of the pool of candidates from which they will recruit.

However, analysis of the available data shows that some employers use casual staff where they should use permanent staff. They fill regular positions with casual employees, and use new graduates as casual staff. Given the current average annual paid hours for hospital nurses, and the distribution of full-time, part-time and casual staff, a manager who depends heavily on the deployment of casual nurses to staff 200,000 hours of nursing care - the average amount per year in a community hospital - has to have access to between 58 and 176 nurses.

In a number of hospitals, nurses are first employed as casuals so that the cost of their orientation will be minimal for the employer. These new nurses are assigned to float pools and move between wards as needed without consistent support from a more senior mentor or a group of peers. This causes undue stress.

Hospitals need to organize casual bookings further in advance if they are to use casual nurses more appropriately. Employers should also match employment positions with experience and training and not use a continual flow of different casual staff to fill full-time and regular part-time positions on a continuing basis.

Therefore, the commission recommends that:

15. hospital managers

- **a. develop data bases and monitoring systems to help achieve the appropriate mix of regular and casual nursing staff;**
- **b. use regular full-time, part-time and unit-specific casual nursing staff whenever possible, limiting the use of non-unit-specific casual nursing or agency-recruited float staff; and**
- **c. provide appropriate orientation for new nurses.**

When I first started there were LPNs working on every ward with the exception of ICU. They even worked in the intensive care nurseries, in the nursery, and in emergency. These positions have all been cut now.
UNI-023

The commission was repeatedly told that the current LPN to RN staff mix is inappropriately tipped towards RNs. We were told that:

- changes in the philosophy of nursing care – from team to primary care – caused the lay off of LPNs in favour of RNs
- since 1981, there has been a 30 percent reduction in the number of LPNs working in acute care hospitals
- the ratios of LPNs to RNs and LPNs to the population in BC are the lowest in Canada
- many of the tasks and functions of nursing may be performed by an LPN
- what LPNs are allowed to do varies from hospital to hospital, and sometimes from unit to unit
- RNs are overworked and LPNs underutilized
- the perceived provincial nursing shortage coincides with the trend to substitute RNs for LPNs.

These are important issues for a provincial health care personnel plan, given the high proportion of total hospital costs attributable to nurses. From 1968 to 1989, the salaries paid to nurses outstripped the Canadian Consumer Price Index by approximately 35 percent and the province's average weekly earning rate by 16 percent.

As stated in the preamble to this report, this commission strongly believes that ***all tasks within the health care system should be performed by personnel with the education necessary to achieve high quality care***. That has not been the case in the nursing profession where the role of the RN has been expanded to include the role formerly occupied by the LPN.

The material placed before us clearly indicates that the cost of providing nursing services in this province has increased in conjunction with the replacement of LPNs with RNs. Initially, RNs replaced LPNs because it did not increase hospitals costs. But that situation has changed, and LPN wage rates are now only about 67 percent of RN wage rates.

The commission was told of an instance in Kamloops in which 50 LPNs were replaced by approximately 50 RNs. Based on the top range for the two groups, this shift to RNs created a cost increase in 1991 of approximately $687,000, all of it in the acute care sector. There is no available evidence that patient care improved as a result. This leads us to conclude that the drastic reduction in the number of LPNs in BC has been a mistake.

RPNs are also well trained for the role they now and formerly occupied in psychiatric and psychogeriatric wards. But like LPNs, they have been, and continue to be, replaced by RNs. This is an inappropriate use of health care personnel.

Therefore, the commission recommends that:

16. the Ministry of Health require the use of licensed practical nurses and registered psychiatric nurses in hospitals, *long term care facilities, and elsewhere, where their employment is consistent with efficiency and quality care.

A recent provincial policy to encourage hospital and community partnerships has allocated 1 percent of hospital budgets to community-based programs. That 1 percent is held back and hospitals are encouraged to submit proposals for community-based programs in conjunction with community agencies. Other community-oriented initiatives originating from the Ministry of Health are discussed in ***Mental Health*** and ***Long Term Care.*** These include the deinstitutionalization of mentally ill patients and the substitution of *home care for *personal care services in the long term care program.

This shift in focus from institutions to the community has serious implications for nursing. The emphasis on outpatient services and the limiting of admissions to acute care facilities to those who truly require acute care, as recommended in ***Careful Spending*** and ***Hospitals,*** will create more opportunities for nurses in the community. There, they will have to act more independently than in the hospital setting, and will require different decision-making and case management skills.

• *Hospital Culture and Nurse Retention*

Employers must recognize that the role of women in society has changed. As women's career options have increased, so has their discontent with the working conditions they find in the institutions which traditionally employ them. High turnover rates are indicative of this, and some aspects of hospital culture – shift work in particular – cause serious problems for the hospital nurse.

Rotating shifts and 12-hour shifts were created in response to demands by nurses, but as the work force has aged, family responsibilities now often conflict with shifts, and wage differentials have not attracted the number of nurses required for permanent late shifts. The need for on-site child care and secure parking, the lack of staff rooms and a perception that nurses lack meaningful input on hospital committees, all contribute to dissatisfaction with the workplace.

I honestly don't believe there is a shortage of nurses. There's a misuse of nurses.
HCP-161

Nurses spoke to the commission a number of times on this subject. The Richmond Delta Chapter of the Registered Nurses Association of BC (RNABC) suggested that the quality of the nursing environment could be improved by:

- involving nurses in hospital decision-making
- improving the workplace environment
- providing incentives which focus on job satisfaction
- clearly communicating management's standards for, and expectations of, nurses.

* GLOSSARY

It is clear that nurses feel that increasing their participation in clinical and administrative decisions and in *quality assurance programs will enhance their self-image and improve their morale. This participation, if it is consistent with the efficient and effective delivery of care, should be encouraged by the institutions and the nurses themselves, wherever possible. Health care workers must participate in a meaningful way in the operation of hospitals if there is to be an improvement in hospital culture and working conditions.

A three-week pilot exchange program between intensive care units at Laurentian Hospital and Sudbury General Hospital in Ontario has been designed to enhance job satisfaction, employee self-esteem and patient-care management skills. Nurses who have completed the program apparently return to work with a sense of personal pride, and knowledge and skills that are valuable to their units. A similar project could be undertaken here.

Therefore, the commission recommends that:

17. a. nurses participate in clinical and administrative decisions in all institutions; and

b. head nurses and other nurses who have assumed managerial roles should not be within the nursing bargaining unit.

A number of the nurses who appeared before the commission suggested that, as most nurses are women and many of them take time off during childbearing years, they suffer financially if they take early retirement. These nurses asked us to recommend removing the penalty for retiring before age 60.

Although the commission is sympathetic to this suggestion, it is a very broad issue which encompasses more people than just nurses and involves fundamental questions of public policy that can only be answered by legislation or through collective bargaining. At one time, the nurses' pension plan did allow retirement at age 60 with correspondingly higher contributions. Nurses chose to discontinue that plan.

• *Remuneration and Compensation*

The relationship between career development and wages is a complex one. A nurse's earnings are controlled by a wage grid in which the minimum and maximum levels have remained within the same range for a decade. This range has been narrow for all nursing groups, limiting their sense of long-term career opportunities, but it is particularly narrow for the LPNs whose four-step grid only covers a 7 percent difference in wages. General duty RNs have a six-step grid which has preserved a 15 percent difference between entry-level and maximum hourly wages for all classifications for the last ten years.

Therefore, the commission recommends that:

18. the parties to collective agreements negotiate increased differentials between first year and experienced RNs, LPNs and RPNs.

• *Alternative Education Models*

A graduate nurse is trained as a generalist, and is expected to be competent in the five areas defined by the registration exam: surgery, medicine, obstetrics, paediatrics, and psychiatry. The extent of a nurse's clinical preparation is determined by the RNABC, the licensing body with the legislative right to approve educational qualifications preparatory to entry-to-practice.

In 1988, the vast majority of practicing RNs (84%) had diploma-level education while only a small number had university degrees: 6 percent had received baccalaureates preparatory to practice; 10 percent had a post-secondary degrees as well as a diploma in nursing; 1 percent were baccalaureate nurses with further degrees in nursing and other fields. The proportion of younger nurses with a baccalaureate or diploma and post-basic degree was somewhat larger than for all nurses.

Complex medical technology, the growth of knowledge, and the shift to community-based care all warrant advanced qualifications. But the central questions for health care personnel planning must be what types of education and what mix of nursing personnel are needed to meet the health care needs of this province.

The RNABC argues that, as medical technology and treatment become more complex, the need for special clinical preparation becomes more important. Therefore, according to the association, a Bachelor of Science in Nursing (BScN) should be the *minimum* requirement for entry into nursing by the year 2000.

The commission rejects this argument. Making the BScN the minimum requirement for entry into nursing is inconsistent with the principle that employees within the health care system should not be required to have a higher level of education, training, or accreditation than is necessary to perform the required tasks. Upgrading the training of personnel and paying all nurses at the baccalaureate level would also raise costs per patient day at all levels of care, a topic discussed more fully in ***Careful Spending.***

We want to be clear on this point. We are not opposed to the BScN. We are opposed to the degree being used as an entry-level requirement. There can be little doubt that the majority of nurses currently practicing in the province – diploma RNs – are competent, valuable nurses.

One of the commissioners was not prepared to recommend rejection of the baccalaureate degree as an entry-level requirement.

Therefore, the commission recommends that:

19. the policy to make the baccalaureate the minimal entry-level requirement for nursing be rejected.

We recognize that as programs and facilities permit more patients to be treated in the community, the patients who remain in the hospital will require a higher level of medical care. An increase in the number of BScN *public health nurses, community nurses, and nurse educators is also necessary if health care is to shift from the institution toward the community. This may mean an increase in education for all nurses.

Rather than making a baccalaureate the minimum entry requirement, there should be a continuum of education throughout all of nursing. For example, a person who is trained and works as an LPN should be able to train to become a diploma RN, receiving credit for education and experience as an LPN. Similarly, an RN diploma nurse who wants to go on to obtain a baccalaureate should be given credit for previous education and experience. This would provide a flexible career ladder for nurses, ensure appropriate levels of education and training for bedside nursing, and give practical experience to those who will eventually become baccalaureate nurses.

Entry to practice requirements for nurses will be a Bachelor's degree by the year 2000. Degree nurses are not going to stay at the bedside under the existing conditions.
HCP-220

* GLOSSARY

Therefore, the commission recommends that:

20. there be a continuum of education from nurses' aide to LPN to Diploma RN to Baccalaureate RN, and that nurses licensed at each level of the continuum be employed at the highest level possible given their skills. Professional associations should not have the power to interfere with this policy.

Nurses in BC are trained at a number of different colleges, at the BC Institute of Technology, and at two universities. Because the universities receive global funding, the Ministries of Health and Advanced Education, Training and Technology have little influence on either the number or mix of nursing specialty programs. The colleges, on the other hand, must make submissions for funding and, therefore, have a strict protocol for developing new programs.

We believe that the curricula of the schools of nursing and diploma programs must be based on the needs of the population identified in the provincial health care personnel plan. The programs must coincide with the needs of the population as a requirement for funding.

Providing a flexible career ladder for nurses and the changing demands of health care will require a significant amount of cooperation between the educational institutions and a wide variety of disciplines. This is a positive step, and the commission strongly rejects any system which lacks the closest cooperation between the metropolitan schools of nursing and the diploma programs in other parts of the province.

On a more general note, in ***Governance of the Health Care Professions*** we have referred to the barriers that exist between the various health professions, and the fact that this is detrimental to the system and the patients. We think that it would be helpful if there were less isolation when students are developing into professionals. More involvement of teachers from other disciplines in health programs generally might give students a better appreciation of and respect for other disciplines.

Therefore, the commission recommends that:

21. training institutions

a. encourage cross-faculty teaching and other educational practices that reduce the walls between professions;

b. respond to the needs identified in the provincial health care personnel plan; and

c. collaborate, cooperate, institute transferable credits and increase inter-disciplinary instruction.

As well as the three nursing groups referred to in this chapter, there are many nurses' aides employed in BC. Nurses' aides should be encouraged in their jobs and permitted to perform the tasks for which they are qualified and which they are capable of performing. As stated in recommendation #20, they too should have an opportunity to upgrade. ***Labour Relations, Careful Spending*** and ***Hospitals*** discuss other issues of importance to nurses.

ALLIED HEALTH CARE WORKERS
•Changes in Service Delivery

Changes in the delivery of health care services, whether intended or under way, will affect the province's personnel requirements. These changes include:

- a move away from institutional care toward community-based outpatient care
- an aging population and a increase in the need for extended care facilities
- an increase in the delivery of services by home care workers.

The move to deinstitutionalize the mentally ill, discussed in ***Mental Health,*** and to integrate the mentally and physically disabled into the school system and the workplace, discussed in ***Services to People with Disabilities*,** is already well under way. Subject to the qualifications expressed in ***Mental Health,*** the commission favours these trends, and favours the reinvestment of resulting savings in the appropriate support services.

The decreased reliance upon institutions for rehabilitative and supportive care has major implications for the design of the provincial health care personnel plan. However, an accurate analysis of the supply of and demand for physiotherapists, occupational therapists, audiologists and speech and language pathologists, psychologists, social workers and other allied health care workers, is hampered by a lack of data and by the poor quality of the data that exist.

Therefore, the commission recommends that:

22. the provincial health care personnel plan identify the need for rehabilitative and other health care workers as health care shifts from institutions towards the community and the home.

•Employment

Private sector employment – whether self-employment or institutional employment – is an option for all allied health care workers, particularly for physiotherapists, one-quarter of whom are already working in the private sector, and for psychologists. Private practice can offer flexibility in hours of work as well as the potential for a broader *scope of practice.

Now that medical referrals are not necessary in all cases, the degree of autonomy for some allied health care workers is virtually identical to that of physicians, with the exception of their limited access to MSP. For example, the number of visits to a physiotherapist covered by MSP is limited to 12 treatments per year. The commission heard a number of people speak on this point and concludes that in some cases this number of treatments is inadequate.

The real difficulty lies with an absence of integrated manpower planning.
SOC-006

Although private practice for occupational therapists is not now covered and is unlikely to become covered by MSP, the expansion of the community care system may offer an opportunity for therapists in private practice to provide services by contract. The provincial health care personnel plan will need to take this into consideration when it calculates the future supply and distribution of occupational therapists.

* GLOSSARY

Therefore, the commission recommends that:

23. the Medical Service Plan's limit of twelve treatments per year by a physiotherapist be increased at the direction of an attending physician.

24. rehabilitation therapists in public and private practice be allowed to provide services to patients in the community and, where appropriate, in institutions.

Given the nature of a psychologist's range of skills, and in view of the fact that psychiatrists are in short supply, it is practical to employ psychologists extensively in public institutions such as community clinics and mental health centres. Where psychologists are employed in hospitals, they should have autonomy. General practitioners should not have to refer to a psychiatrist in order to have a patient seen by a psychologist. Access should be direct.

Therefore, the commission recommends that:

25. the ministry of health expand the public sector role of licensed psychologists.

> *We feel that the use*
> *of a trained assistant*
> *can very much enhance our service,*
> *but in order for us*
> *to protect our clients,*
> *we feel there has to be*
> *an elementof supervision.*
> PRO-120

Social workers traditionally work within the public service, but they frequently go into private practice – often in counselling – once they have aquired a degree. Social work tends to overlap with the practices of other disciplines, most notably psychiatric nursing and psychology. The potential for inter-disciplinary conflict is therefore particularly acute in institutional settings, and must be carefully managed.

•*Rehabilitation Aides*

Rehabilitation aides with various degrees of competence are employed in Ontario and Quebec. In Ontario, they undergo a brief education, then work under the direction of a physiotherapist or an occupational therapist. In Quebec they train for three years and are used in the absence of physiotherapists. In that province, they are known as rehabilitation technicians and work principally in mobile clinics and outlying regions.

The concept of rehabilitation aides was discussed at a number of public hearings and the attitude of some professionals was disturbing. They argued, in effect, that it is better for citizens in remote areas of this province to receive no rehabilitation therapy at all rather than minimal therapy from an aide. The commission rejects this argument while recognizing that the employment of aides does raise a number of questions about quality of care and scope of practice.

Rehabilitation aides are trained to perform a limited range of tasks under the supervision of a therapist; however, their job description is the responsibility of their employers. If the role of these aides begins to expand – more tasks, longer training, more autonomy – it is possible that they will come to be seen as a substitute for therapists, especially in smaller facilities.

In BC, it was first proposed that physiotherapy assistants would be trained to augment physiotherapists who are in short supply in the province. These assistants were to work in the institutional sector under the direct supervision of physiotherapists. But, after a closer look at the requirements of the health care system, the curriculum was expanded to enable them to help in a variety of therapeutic interventions and to work as rehabilitation aides.

A ten-month program has been instituted at Okanagan College. It graduated its first class of 20 assistants in June of 1991. They are qualified to help therapists who are increasingly in demand because of our aging population. We expect that they will be employed in the long term care sector as well as in other public facilities.

Therefore, the commission recommends that:

26. the Ministry of Health, in cooperation with the Ministry of Advanced Education, Training and Technology, establish additional programs to train rehabilitation therapy aides to work under the supervision of rehabilitation therapists.

27. in situations where therapists are not available, rehabilitation therapy aides be allowed to work independently.

28. in situations where rehabilitation therapy aides are employed, well-defined, enforceable guidelines be established covering scope of practice and supervision.

•*Chiropractors*

One of the issues most frequently before the commission was the question of whether chiropractors should be permitted to treat their patients after they are admitted to an institution. In our opinion, long term care facilities should be treated as the patient's home and there should not be barriers between patients in these facilities and the care providers of their choice.

Therefore, the commission recommends that:

29. where the patient of a chiropractor is admitted

- **a. to an institution other than an acute care hospital, the chiropractor be permitted to treat the patient in the institution, at the patient's request, unless the attending physician determines that the treatment is detrimental to the patient's health; and**
- **b. to an acute care hospital, the permission of both the attending physician and the institution be required to allow a chiropractor to treat the patient.**

In either of the above circumstances the institution bears no legal responsibility for the treatment provided by the chiropractor.

In making this recommendation, the commissioners are somewhat concerned that there may be a significant increase in inappropriate treatment by chiropractors. While we recognize there is a role for chiropractors, some of the *submissions they made to us suggested they could treat a wide range of illnesses including measles and leprosy. We reject this. In making the recommendation that they be permitted to treat their patients in institutions, we specifically charge the BC College of Chiropractors with the responsibility to make certain that inappropriate treatment does not occur, and suggest that the Ministry of Health keep a wary eye on the use of chiropractors in such circumstances.

A second matter frequently brought to the commission's attention was the availability of x-rays. Patients and chiropractors alike argued that it is inappropriate for a patient who has already had an x-ray to have to obtain a second one because the first was not made available to the chiropractor. This seems inefficient and wasteful.

Therefore, the commission recommends that:

30. a physician or institution be required to provide a copy of an x-ray at cost to a patient on request.

The number of times a person is permitted to see a chiropractor each year was also raised at the hearings. Currently, MSP subsidizes 12 visits to a chiropractor each year for patients under 65 years of age, and 15 visits for those over 65. A number of chiropractors and patients argued that this limit is arbitrary and inappropriate and that both the Insurance Corporation of BC and the Workers' Compensation Board frequently finance more than 12 or 15 visits.

We were also told that the average chiropractic patient requires less than 12 to 15 visits. Although we were unable to independently confirm this, the commission accepts the argument and concludes that there should be some flexibility to permit chiropractors, at their professional discretion, to increase the number of treatments for particular patients. Of course, only medically necessary chiropractic services are subsidized by MSP, and the regular treatments some chiropractors recommend do not qualify as medically necessary.

Therefore, the commission recommends that:

31. the limit on visits by a patient to a chiropractor in any one year be reduced to 10 visits per year for persons under 65, and 12 visits per year for those over 65. A number of visits equal to one-fifth of the total number of visits billed by the chiropractor in the previous year be allotted to each chiropractor to be used for those patients who require more than 10 or 12 visits.

MIDWIVES

• The Labour Dispute

Midwifery is a widely accepted practice. Its birth outcomes compare favourably with those of more expensive and intrusive medical care models, and a growing number of people want the right to choose a midwife to aid them in their pregnancy. Although the data are unavailable for BC, surveys in Ontario and Quebec have shown that general practitioners are moving away from obstetrics. In Ontario, obstetricians now attend over 67 percent of all births. In the majority of cases, this is expensive and inappropriate. It is time to re-examine midwifery in BC.

Statistics support midwifery. Sweden, with the world's lowest *perinatal mortality rate, uses midwives for most hospital deliveries. Finland, Norway, Denmark, France, Switzerland, New Zealand and Australia all have better birth outcomes than Canada and all use midwives. In fact, we are one of only nine countries belonging to the 210 member World Health Organization (WHO) that do not recognize midwifery as a profession. The other eight are Venezuela, Panama, New Hebrides, Honduras, El Salvador, Dominican Republic, Columbia and Burundi.

The use of midwives as preventive, primary care workers is recommended by WHO as the chief means of reducing costs associated with unnecessary medical interventions in childbirth. Money is saved through decreased reliance on medical interventions, shorter hospital stays, and reduced *morbidity. WHO also considers caesarean section rates in excess of 15 percent unjustifiable. Our current caesarean section rate is 21-25 percent. Yet the Grace Hospital midwifery project has consistently shown caesarean section rates of less than 10 percent. (We recognize that this may be due to a lower number of higher-risk pregnancies among the participants in the midwifery program.)

Midwifery is illegal in Canada; however, Ontario, Quebec and, most recently, Alberta are all in the process of changing this. As the result of an exhaustive study in Ontario, the province is legalizing midwifery and establishing it as an autonomous profession. Quebec has agreed to legalize midwifery in a limited number of pilot projects and Alberta is now in the process of recognizing a form of autonomous midwives.

Ontario's midwives will be an autonomous, self-regulating profession, licensed to manage pregnancy, labour and delivery for low-risk women. The scope of practice proposed under Ontario's Midwifery Bill 195, 1990, includes:

- managing labour and conducting spontaneous normal vaginal deliveries
- performing specified episiotomies and amniotomies and repairing episiotomies and lacerations
- administering a substance by injection or inhalation
- putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the postpartum period.

The Ontario Task Force on the Implementation of Midwifery has also outlined a two-stream education program to take advantage of students' previous educational backgrounds. Those with direct entry do a four-year degree program; those possessing a BScN do a diploma course lasting 12-18 months.

A number of people raised the question of endorsing autonomous or nurse-midwives. Although the RNABC supports the adoption of nurse-midwives and recommends that they have a nursing baccalaureate as well as two years in a midwifery program, many midwives, including nurse-midwives, do not feel that they should be grouped in the field of nursing. They argue that a nursing degree is not necessary for the practice of midwifery and would ultimately draw them into the current interventionist model of health care delivery. The BCMA has stated that it sees no need for midwifery, but both the BCMA and the College of Physicians and Surgeons are currently considering the incorporation of nurse-midwives into the health care system.

*Regardless
of the risk factors
a midwife-based system
is an excellent way
of coming up
with good outcomes,
superb outcomes.*
HCP-247

*** GLOSSARY**

Due to the number of qualified midwives in BC, and the expense and length of time necessary to organize a college, we are recommending a two-step approach to the establishment of midwives in BC. Nurse-midwives are the logical first step. They are already sanctioned by the BCMA, College of Physicians and Surgeons, and the RNABC.

Therefore, the commission recommends that:

32. pending the establishment of a College of Midwifery,

- **a. nurse-midwives be granted an appropriate scope of practice under the Nurses (Registered) Act;**
- **b. the Medical Practitioners Act be amended to provide an exemption to midwives; and**
- **c. midwives be allowed to deliver babies in hospitals.**

Hospitals should set up birthing centre facilities staffed by nurse-midwives using the Grace Hospital Project model; however, home births should be prohibited until Canadian studies have been conducted. Costs should be monitored carefully to ensure that midwives do not become an 'add-on' to the health care system.

Ultimately, though, midwives should be licensed and regulated by a separate College of Midwifery established pursuant to the Health Professions Act. The privilege of self-regulation is the topic of ***Governance of the Health Care Professions.***

Therefore, the commission recommends that:

33. upon application, the Health Professions Council approve the establishment of a college to regulate the practice of midwifery.

34. nurses be permitted to be members of both the RNABC and the College of Midwifery.

35. costs associated with midwifery care not exceed those associated with physician care.

LABOUR RELATIONS

A number of factors influence labour relations in the health care field. One is the almost sacred status that health care enjoys in the public's opinion. Another is that profit is not a motive for public sector employers or employees; their collective agreements exert very little pressure to perform efficiently.

It should be remembered that the collective bargaining process is only one aspect of labour relations and that the different groups have generally done a better job of labour relations at the bargaining table than they have done during the life of their contracts. The trust and support, or mistrust and opposition, created over years of bargaining shape the complex relationships between unions, associations, government and management.

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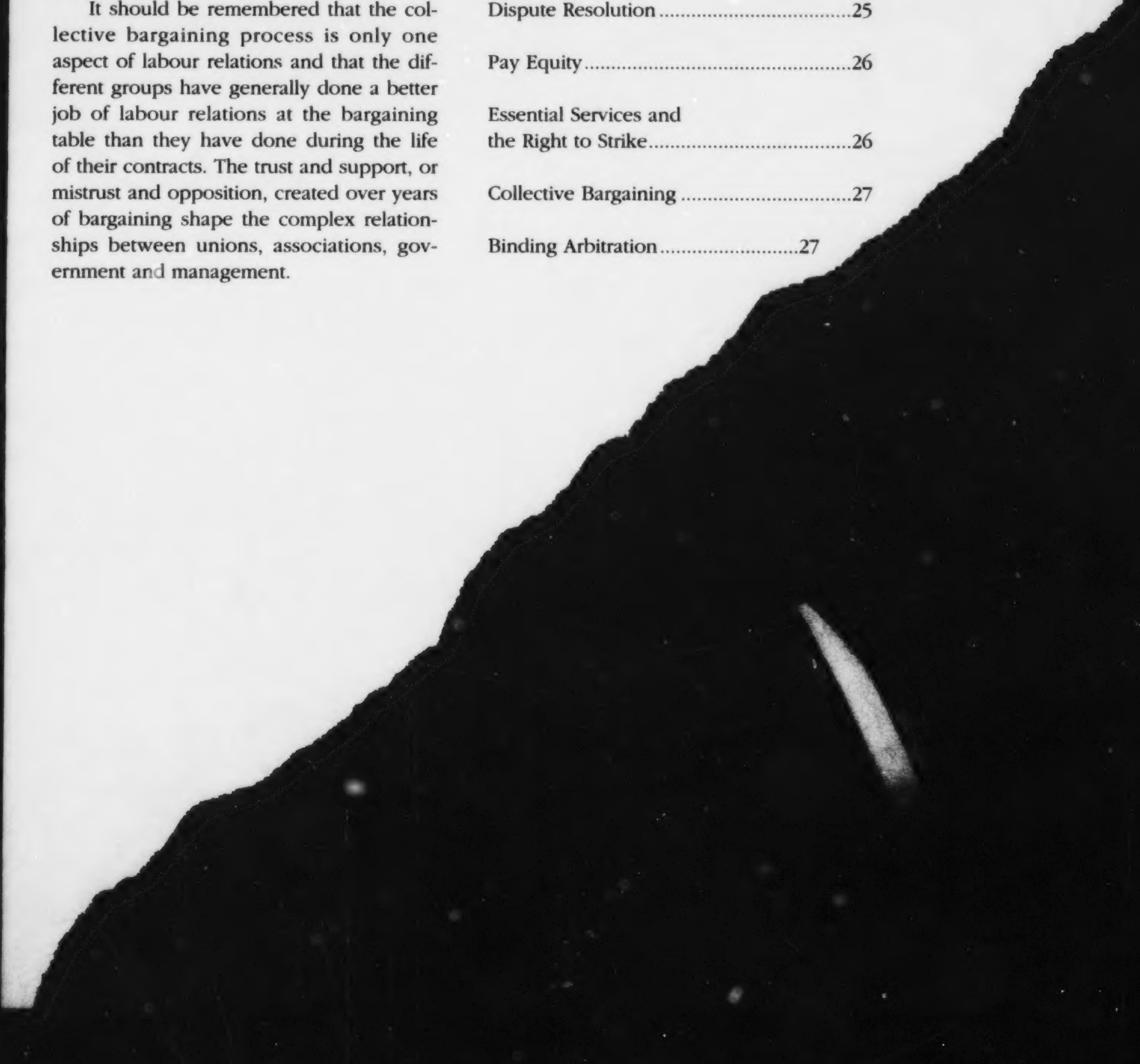

Most health workers are unionized, the principal bargaining units being the BC Nurses' Union, the Health Sciences Association of BC, the Hospital Employees' Union, the BC Government Employees' Union, the Union of Psychiatric Nurses, the Canadian Union of Public Employees, and the International Union of Operating Engineers. The BC Medical Association is not a union, but it bargains on behalf of approximately 90 percent of the province's physicians.

The Health Labour Relations Association (HLRA) represents the majority of acute and *long term care institutions. The Continuing Care Employee Relations Association (CCERA) and PRICARE represent the remainder of those employers.

Current Legislation, Regulation and Enforcement

The Industrial Relations Act superseded BC's Labour Code in 1987, replacing the Labour Relations Board with the Industrial Relations Council. The Act provides that the Council have at least two divisions: currently, Industrial Relations Adjudication and Disputes Resolution.

Provincial labour law acknowledges specialized tribunals as appropriate bodies for solving problems. And as a labour tribunal, the Council has broad powers to establish labour relations policies and practices, and to monitor and intervene in the bargaining process or in labour disputes. The Adjudication Division decides questions relating to certification and de-certification of bargaining agents, as well as investigating unfair labour practices and matters relating to strikes, lockouts and picketing. The Disputes Resolution Division, which did not exist under the Labour Code, monitors collective bargaining and any labour dispute in the province, and assists the parties in reaching a settlement. This Division also provides mediation services required under the Act and is responsible for collecting and compiling information and statistics about industrial relations in BC.

Prior to 1987, the Essential Services Disputes Act dealt with all matters relating to essential services. However, that Act was repealed in 1987 and authority to make essential service designations was given to the Industrial Relations Council. The new legislation has expanded the essential service criteria, making it easier to use the designation. The Minister of Labour retains the power to determine whether an essential services designation should be invoked, or a cooling-off period ordered. The minister also has the power to appoint

- an Industrial Inquiry Commission to keep industrial peace in the province
- an arbitrator if the parties to a dispute cannot agree upon one.

The courts tend to defer to the industrial relations tribunals in the labour relations area unless the decisions of these bodies are patently unreasonable or beyond their jurisdiction.

The existing system does not have labour's confidence and it has not been effective. There is a formal boycott of the Industrial Relations Council by labour. Other bargaining agents have only used the Council selectively, although bypassing the Council has not been legally sanctioned. A system for monitoring and regulating labour relations will not work without the support of all of the parties.

Therefore, the commission recommends that:

1. **the provincial government revise the Industrial Relations Act after consultation with labour and management, to create a labour relations tribunal with structure and powers acceptable to all parties.**

Demographic Pressures

Changes in the population are changing the labour force in health care. For example, the work force now has a larger number of workers closer to retirement age than to the beginning of their careers. This means that younger members of the work force must support health and retirement packages negotiated on behalf of older workers through a process which the older workers control.

Demographic shifts also mean that:

- there are shortages of workers in the lesser skilled, entry level positions
- there are more health care workers from families where both spouses work
- there are more single parent workers
- there are more women working in an industry where they already form the majority of the workforce.

As pointed out in ***Health Care Personnel***, many people argue that the hospital environment should be made more attractive to employees at the lower end of the pay scale and to women generally. This could include:

- a broader employee participation at all levels in workplace decisions
- a greater emphasis on in-service training
- the creation of multi-level career ladders
- specific attention to security for female employees
- providing child care.

Therefore, the commission recommends that:

2. **there be broader participation in decision-making in health care organizations, and more support for women in the labour force, including such things as child care, designated parking and security for shift workers.**

Dispute Resolution

While collective bargaining is central to labour relations, it has its limitations.

- Some questions raise broad policy issues which cannot be solved by the parties.
- Some issues extend beyond the life of a collective agreement and require long range planning.
- Some issues get lost in the give and take of negotiations.

If the parties to a collective agreement worked to solve small disputes during the life of the agreement, they could develop more equitable contracts than those arrived at in the heat of a major dispute.

Therefore, the commission recommends that:

3. **the parties to a collective agreement meet on a regular basis to develop human resource policies and, where possible, to resolve disputes during the life of the collective agreement.**

Pay Equity

Many *submissions to the commission argued that the potential supply of workers would increase with pay equity. This increased worker pool would then put downward pressure on wage levels, bringing down the cost of health care. However, ***the real argument in favour of pay equity is that it is fair***.

Many health care occupations remain underpaid for the simple reason that they are largely performed by women.
UNI-011

Therefore, the commission recommends that:

4. pay equity legislation expressly applicable to the health care sector be enacted and, pending enactment of the legislation, management and unions move to recognize pay equity.

Essential Services and the Right to Strike

There are wide variations among provinces in the right of public sector workers to strike. Some provinces prohibit strikes and require binding arbitration in the hospital sector. Others permit a restricted right to strike, and still others an unrestricted right.

In BC, hospital employees have a restricted right to strike, i.e., they may strike unless the Industrial Relations Council designates them as essential to patient safety. A critical feature of this system, then, is the need to have some agreed upon method for deciding what is essential.

The Industrial Relations Council should automatically initiate the essential services designation process one year prior to the expiry of a collective agreement.
EMP-015

The commission was told that in this province, during strikes, the shared responsibility of employers, unions and government to protect the public interest is taken very seriously. We were also told that as long as legal strike votes are taken, essential services are designated in advance and due process of law is exercised, strikes in the health care sector do not have dire consequences for the public. Although predetermining essential services is not always seen to be necessary for safety, many groups see it as important to public confidence.

Among government, labour and management, however, opinions vary as to whether such planning and control prevent the potential benefit of strikes. Strikes force parties to negotiate. They can serve as a safety valve to release pent-up frustrations, or force an interaction by requiring unions, employers and government to develop contingency plans for patient care. Some nurses' unions have gone so far as to formally organize their efforts to ensure patient safety during recent Canadian strikes. These unions make it clear that while they take some responsibility for patient care during strikes, they see the hospitals as liable for any claims for nursing services that are not provided.

The commission concludes that it is appropriate to designate essential services well in advance of strikes, both to ensure public confidence and to foster discussion between labour and management. When a position is designated as essential, it remains essential regardless of which bargaining unit is involved in the job action. Therefore, employees in positions designated as essential must cross a picket line whether it is put in place by their own union or some other union.

An industrial relations tribunal should administer essential services arrangements during job actions. But if the system is to work, the tribunal must be independent.

Therefore, the commission recommends that:

5. during the life of the collective agreement, the parties shall designate essential services.

Collective Bargaining

Collective bargaining in health care, and in hospitals in particular, is centralized and province-wide in structure. A number of employers have formed associations for bargaining, such as HLRA and CCERA, and two or three unions are involved with most employers. Province-wide master agreements are common, with only some non-wage issues being handled at the local level. This type of centralized bargaining may contain costs, to some degree, by avoiding playing one group off against another and by economizing on administrative costs.

HLRA has suggested that the provincial government sanction it as the exclusive bargaining agent for all unionized non-profit health care institutions in the province. In general, we support a move toward one independent agent bargaining for management, and a significantly reduced number of bargaining units acting for the unions. Such a move would increase the flexibility of the system as it places greater emphasis on providing services in the home and in the community. A myriad bargaining agents do not foster mobility and multi-skilled services. Nor does a number of associations bargaining on behalf of employers encourage uniformity of working conditions.

Therefore, the commission recommends that:

6. both employers and unions move to reduce the numbers of bargaining agents and units.

Binding Arbitration

Some submissions to this commission argued that the collective bargaining process is a barrier to innovative planning in health care and should be replaced with binding arbitration. It is not unions or management that these submissions criticize, but the adversarial roles they play, which many people see as unsuited to the challenge of a competitive labour market. However, binding arbitration has serious implications for labour relations, particularly considering that very little discussion appears to happen between talks at the bargaining tables. Labour, management and government all find the frequent suggestions that they should resort to binding arbitration unsettling.

We share these concerns. An arbitrator only enters negotiations for a brief period of time. Calling one in on a specific dispute will not, in the long run, assist the parties. Settlements that are negotiated by the parties themselves are always preferable.

Therefore, the commission recommends that:

7. binding arbitration not be used as a substitute for collective bargaining.

> ***When you look at mandatory arbitration, you don't fix the problem. You don't fix the problem, because it just festers.***
>
> UNI-011

GOVERNANCE OF THE HEALTH CARE PROFESSIONS: THE PRIVILEGE OF SELF-REGULATION

The purpose of regulating members of a profession is to protect the public from preventable harm. The privilege of self-regulation is granted to a profession by the provincial legislature. It is a social contract between the profession and the public. It is the property of the public the profession claims to serve.

In any other realm of the free enterprise system,
the current control by the profession
of medicine on utilization of dollars,
entry into the health care system,
and control of the referral system,
would be considered a monopoly.
HCP-188

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The Current Legislation

There is a lack of consistency among the 16 provincial acts that govern the health care professions, despite the fact that all of the colleges established under the acts have the same legislative mandate: to protect the public from preventable harm. Such inconsistency increases the likelihood of variations in judicial interpretations of the acts. Underlying this situation are persistent jurisdictional disputes and a distinct lack of cooperation among the health care professions.

These can be explained by historical developments, but that is not a sufficient reason for allowing them to continue. They cloud professional relationships and preserve unequal relationships between licensed and registered professionals. Such problems will only become more acute with the growth of new disciplines. The variations in the acts which currently grant self-regulation to health care professions in BC include:

- the terminology used
- the exclusive scopes of practice granted
- the protection of occupational titles
- the management of complaints, discipline and appeals
- the nature of the offences created by breaching a *scope of practice.

Removing these variations is complicated by persistent territorial disputes. For example, the College of Physicians and Surgeons is concerned about the possible erosion of physicians' scope of practice by "alternative practitioners," while other professions describe the physicians' broadly stated scope of practice as a monopoly that does not serve the public interest.

Problems with the existing legislation and its enforcement are being further compounded by the introduction of new technologies and information. The result has been rapid changes in professional activities and the growth of new and often highly specialized professions. These new professions put pressure on the existing professions to give up parts of their exclusive scopes of practice, while the existing professions are, at the same time, trying to expand their current scopes to encompass the changes.

The Health Professions Act came into effect recently. Under this new Act, a three person Health Professions Council has been established. That Council will review applications by health professions seeking to establish their own colleges and decide whether it is in the public interest to grant the profession an *exclusive scope of practice, what that scope should be, and what occupational title should be protected. The Cabinet will make the final decisions.

Therefore, the commission recommends that:

1. **the existing health care professions acts be repealed and a revised Health Professions Act become the umbrella act for regulating all health care professionals with**
    - a. **the provisions unique to any one profession retained in smaller satellite acts;**
    - b. **all health care professions involved in the consolidation of the existing legislation; and**
    - c. **no subsequent change to the Health Professions Act or one of the satellite acts to take place without prior review and approval of that change by the Health Professions Council.**
2. **to ensure the proper delegation of authority throughout the acts as well as regulations and by-laws,**

I believe it's section 72 of the Medical Practitioners Act, which is very specific about who may do what to whom, and it's basically: doctors can do everything, and nobody else can do anything.
HCP-009

a. the major public policy issues be addressed in the acts acts be approved by the Legislature. These would include:
   i. defining the exclusive scope of practice;
   ii. specifying the use of occupational titles;
   iii. establishing codes of ethics;
   iv. determining what constitutes unprofessional conduct and conflict of interest;
   v. permitting appeals to the Supreme Court; and
   vi. defining the duty of confidentiality;

b. the less substantive issues be addressed in regulations approved by the Cabinet. These would include:
   i. qualification of members to a college board of directors, election procedures and filling of vacancies;
   ii. classes and conditions of membership;
   iii. standards for membership, including educational requirements;
   iv. specialist requirements;
   v. reporting disciplinary decisions;
   vi. professional advertising;
   vii. college records;
   viii. a register of members;
   ix. inspecting a member's practice;
   x. membership reporting requirements;
   xi. exemptions from the regulations;
   xii. the forms required under the Act;
   xiii. details regarding any matter dealt with under the Act; and
   xiv. responsibility for *quality assurance and continuing education programs; and

c. the administrative and internal procedural matters be addressed in college by-laws, be approved by the membership, be filed with the minister of health, and be made available to the public. The minister to have the authority to require that the by-laws be modified. These would include:
   i. adopting a college seal;
   ii. executing documents;
   iii. approval of banking and finance;
   iv. selecting committees and procedures for election to committees;
   v. regulating meetings of the college and its committees;
   vi. appointing officers and the delegation of college powers to those officers;
   vii. prescribing forms for internal use;
   viii. arranging for indemnity insurance;
   ix. regulating membership fees; and
   x. authorizing grants.

Scopes of Practice

Four of the 20 BC health care professions studied for this paper have not been granted an exclusive scope of practice: licensed practical nurses, registered psychiatric nurses, registered nurses and social workers. All of the others enjoy provisions which describe the services they may provide or which non-members cannot provide.

In the past, some colleges were very active in prosecuting non-members who encroached on their exclusive scope of practice. But since 1985, the Attorney General has controlled who will be prosecuted and prosecutions have virtually ceased. This relieves the colleges of the costs involved in pursuing prosecutions and it removes the perception that such prosecutions preserve a monopolistic control over a particular procedure or service.

According to the College of Physicians and Surgeons, the Attorney General's office will not prosecute until there is a significant threat or actual injury to someone by a non-member. Between 1984 and 1990, 116 instances have been investigated by the college: 39 cases were referred to the police; charges were laid by the Attorney General's office in five cases; and, from those, two were successfully prosecuted under the Medical Practitioners Act, two under the Criminal Code of Canada, and, in the last case, the accused left the country.

None of the acts addresses the question of protecting the public from unqualified people who may cause harm to others, except where that harmful act or omission falls within an exclusive scope. No broad provision exists to prevent unlicensed people from providing health services which may cause harm to others.

One example of a jurisdictional dispute which underscores the need to revise the current legislation is the interaction between professions providing foot care services.

Podiatrists have a very broad exclusive scope of practice granted under the Podiatrists Act. This scope includes:

- diagnosis of diseases
- the use of electrical or mechanical treatments
- foot manipulations and minor surgery, such as cutting of corns and callouses.

This scope of practice is so broad that it overlaps that of physicians, so podiatrists have been granted an exception under section 73 of the Medical Practitioners Act. To become a podiatrist, the Board of Examiners in Podiatry has determined that one must complete a four year course of study, which includes courses in minor foot surgery. However, podiatrists rarely perform surgical procedures; orthopedic surgeons undertake the more invasive forms of foot surgery.

Chiropodists, on the other hand, take a three-year college program that does not include courses in surgery. Upon graduation, they can provide basic but important and useful foot care which does not involve surgery.

There are no podiatrists in the northern three-quarters of the province, but because of the podiatrists' scope of practice, chiropodists are prevented from practicing there.

Podiatrists have also convinced the Registered Nurses Association of BC (RNABC) that registered nurses should not provide basic foot care. In a 1989 memo to its members, the RNABC stated that:

> *The B.C. Association of Podiatrists made it very clear... that intervention such as the paring of corns or callouses are clearly protected under their Act... Therefore, independent * nurse practitioners who engage in exclusive podiatry activities as spelled out in the Podiatry Act are in contravention of the Act and will be subject to prosecution. In view of the current legislation, RNABC is obliged to advise its members that they should not infringe on the legislated activity of podiatrists.*

A lot of foot care can be given that does not require professional help. It is commonly given in the home by family members. It is a basic human skill and there is no reason to exclude the nursing staff of any institution from giving needed non-surgical foot care to patients. But the RNABC has been convinced that the Podiatrists Act prevents this.

There is a great need for a wide range of foot care services, in particular for elderly residents in the rural areas. And chiropodists appear just as capable of providing this care as podiatrists without compromising patient safety. If the scope of practice for podiatrists were narrowed to focus on those acts which chiropodists are not trained to do and which have a significant potential to cause real harm, many other foot care services could be safely provided by chiropodists.

This is just one example of why exclusive scopes of practice should be narrowed to focus on preventing harm, as has been initiated recently in Ontario. We believe that more appropriate, cost-effective and timely health care could be provided to more patients if BC were to follow the Ontario initiative.

This example also highlights why it is important to examine the existing scopes of practice of the health care professions before granting any more. To do otherwise would further complicate an already complicated patchwork of prohibitions and exemptions.

Therefore, the commission recommends that:

3. legislation ensure that the exclusive scopes of practice granted in the past and those that may be granted in the future protect the public from the potential harmful acts of those people who are not competent or qualified to perform such acts by adopting the approach recently taken in Ontario.

4. the criteria set out in this chapter should form the basis for the decision to maintain the scope of practice of an existing profession or to grant a scope of practice to a new profession.

5 the evaluation of current and future scopes of practice should involve all health care professionals and, most importantly, the general public.

6. except where a licensed health professional operates within a licensed scope of practice, it be an offense for any person to treat, offer to treat, or advise in respect to any human health condition in circumstances in which the treatment, offer of treatment or advice is likely to result in harm to another person.

The Use of Occupational Titles

It may not be in the public interest to grant an exclusive scope of practice to every health profession. It may, however, be appropriate to grant an exclusive title so that the public will know that the professional with whom they are dealing is regulated by a college.

* GLOSSARY

A number of professions have requested exclusive titles through new acts, or have applied for title protection under the Society Act. To date, 17 health care occupational titles and five sets of initials have been registered under that Act to five different health care occupations. The BC Association of Speech/Language Pathologists and Audiologists alone has registered seven titles: Registered Speech/Language Pathologist; Registered Speech/Language Therapist; Registered Speech Pathologist; Registered Speech Therapist; Registered Voice Therapist; Registered Communication Disorders Specialist; and Registered Audiologist.

However, there still could be confusion as a result of this use of the Act. There is an informal agreement that the Registrar will not grant an exclusive title under the Society Act unless it has been approved by the Ministry of Health. And to further complicate matters, there is no restriction on someone using a title which includes the words *registered, licensed* or *certified* even though they have not been granted a title under the Society Act or the Health Professions Act.

Therefore, the commission recommends that:

7. a. the Society Act be amended so that the Health Professions Council must approve an occupational title or abbreviation before the Registrar grants protection of it;

b. all of the health profession titles previously granted protection under the Society Act that have not been approved by the Health Professions Council be revoked two years after the passing of the revised Health Professions Act; and

c. the Health Professions Act be amended to prohibit the use of words like "registered", "licensed" or "certified" by any health care worker unless that use has been approved by the Health Professions Council.

Improving the Health Professions Act

In general, a lack of consistency characterizes the acts with respect to complaints, discipline and appeals, resulting in insufficient public accountability, no uniformity in the structure or organization of the different statutes, and an absence of common terms. The areas of greatest inconsistency are:

- the college's rule-making authority
- the way complaints are received and addressed
- the requirement to report incompetent members
- the power to discipline former members
- the use of pre-hearing suspensions

- the availability of judicial restraining orders or injunctions
- the description of the acts or omissions which may lead to disciplinary action
- the type of disciplinary action which may be imposed
- the awarding of costs at the end of a disciplinary hearing and the maximum amount which can be awarded
- the procedures by which disciplinary hearings are initiated, held and resolved
- the member's rights, such as notification of hearings and obtaining a decision with reasons
- the procedures to address a member's failure to appear at a hearing
- the college's powers at a hearing
- the right of appeal, what may be appealed and the limitation period for initiating an appeal
- the requirement that an internal review take place prior to initiating an appeal to the Supreme Court and the requirements for such review

Many of the acts also lack a clause to limit what may be appealed to the Supreme Court and the requirement that the Court defer to issues which involve or are based upon the expertise of the members of the profession.

The Health Professions Act has the potential to influence significantly the future of the self-regulation of health care professions. Under this new Act, the Health Professions Council can make recommendations to the minister concerning which groups should be granted self-regulation status, their titles, and the extent of their scopes of practice, if any. The Act could be used to create uniform legislative procedures.

Barriers to Multi-Disciplinary Practice

In addition to broadly stated scopes of practice, there are other barriers to practice. For instance, there is no reason why a member of one profession should not be allowed to be a member of another profession. A provision in any regulation, rule, by-law or Code of Ethics which prevents this from happening is inappropriate. It may be in the profession's interest to have such a prohibition, but it is not in the public interest.

Some of the existing professional legislation makes it an offense for a member of a college to work in association with someone who is not a member of that college. But as long as the non-member does not practice within the profession's narrow scope of practice, the commission does not believe there is any substantial reason why a member of a college should not be allowed to work in cooperation or in partnership with someone who is not a member. In fact, a multi-disciplinary practice may be beneficial and should be encouraged.

Practicing with unregistered person,
84(1)
If a member of the college, without first obtaining the written consent of the executive committee, practices medicine in partnership with, under a contract with or as a business associate of, a person not entitled to practice medicine, surgery or midwifery, or does any act to enable that person to practice medicine, surgery or midwifery, both parties to the partnership, contract or arrangement are liable on conviction to a penalty not exceeding $250 and not less than $100. The council shall erase from the register the name of a member of the college convicted under this section.
Medical Practitioners Act, 1979

Therefore, the commission recommends that:

8. the Health Professions Act be amended to include provision for:

- **a. a common terminology and organization that can be applied to all health care professions;**
- **b. the appointment of lay members to the boards of all of the colleges;**
- **c. the publication of the decisions and reasons of the college disciplinary committee, subject to appropriate protection for innocent parties;**
- **d. the professional and public review of any proposed new college rules or by-laws or significant amendments;**
- **e. the duty to report another member of a college when that member's conduct may endanger the public or constitute unprofessional conduct, with a parallel duty to report members of other colleges to their respective colleges;**
- **f. the acts or omissions which may initiate disciplinary hearings and the types of disciplinary action to be taken with a particular emphasis on incorporating the best provisions existing in the current acts;**
- **g. the addition of specific features of the principles of natural justice and procedural fairness, such as the right to issue subpoenas, the right to obtain and instruct legal counsel, and the right to a copy of the proceedings of disciplinary hearings when an appeal has been initiated;**
- **h. the clarification of which matters must be reviewed internally before they can be appealed to the Supreme Court, with a greater emphasis on an internal appeal mechanism;**
- **i. a clause describing the jurisdiction of the Supreme Court and requiring that the Court defer to the colleges on decisions which are based upon the expertise of the members of the professions;**
- **j. the establishment of a limitation period for initiating either an internal review or an appeal to the Supreme Court;**
- **k. a prohibition against any college limiting the right of a member to belong to another college; and**
- **l. a prohibition against any college limiting the ability of one of its members to work in association or partnership with a member of another college.**

Promotion and Self-Regulation

Many of the professions have colleges which undertake the tasks assigned by legislation. The colleges attempt to maintain the quality of the services their members provide to the public in a variety of ways, such as continuing education programs. The prime task of the colleges is the protection of the public.

Many professions also have membership promotion associations which bargain with the government or employers on issues such as wages and benefits. Associations also undertake various political activities, lobby government, and actively promote the services their members provide. The BC Medical Association and the BC Nurses Union are both membership promotion associations.

Occasionally the roles of the associations and the colleges become blurred, and we have been told of instances where political or labour dispute positions have been actively promoted by a college. As well, some professions, such as dentists, do not have a distinct separation between membership promotion associations and colleges, and these functions are blended together into one organization.

Therefore, the commission recommends that:

9. two separate bodies be created for all regulated or licensed professions so that there is a clear separation of membership promotion functions and licensing and discipline functions. If there are not sufficient members to have a separate college, then a college should not be established.

Criteria for Granting the Privilege of Self-Regulation

Before a profession can be considered for a grant of self-regulation under the Health Professions Act, the applicant must first demonstrate that the members of that profession engage in activities relevant to the jurisdiction and mandate of the Ministry of Health.

1. Is a substantial proportion of the profession's members engaged in activities which come under the jurisdiction of the Ministry of Health? What is the (approximate) proportion so engaged?
2. Is the primary objective of the treatments or services performed by the profession's members for the promotion or restoration of human health, or the reduction of disability or suffering? Without clear evidence of a benefit to public health, safety or welfare, it is unlikely that there will be sufficient reasons to justify granting any form of self-regulation status to a profession.
3. Does the profession provide a direct health benefit or advantage to members of the public?
4. What is the nature of that health benefit? Is the health benefit easily recognizable, or is the benefit so remote or dependent on tenuous argument or unlikely circumstances as to be of questionable significance?
5. Does the core activity the members of the profession perform constitute a clear, integrated and broadly accepted whole?
6. Is the body of knowledge employed by the profession one which is subject to tests of scientific validity?

Once it has been determined that the activities of the profession are relevant to the Ministry of Health and of benefit to the public, the next question is whether or not the profession should obtain a privilege under legislation. Two fundamental privileges are available under a grant of self-regulation:

- the right to use a restricted occupational title
- the right to work in an exclusive scope of practice

All of the other benefits of self-regulation flow from a grant of one or both of these benefits. Whether the first or both of these benefits should be granted to the members of the profession will determine whether they will become registered or licensed professionals respectively.

Without clear evidence of a risk of harm to the public and a demonstration that the profession has the skills or knowledge to reduce that harm, it is unlikely there will be sufficient reason to justify granting an exclusive scope of practice to that profession.

7. Does a substantial risk of physical or emotional harm to individuals exist in or arise from practice by unqualified people?
8. What is the nature of the potential harm to the public? Is it easily recognizable, or is the harm so remote or dependent on tenuous argument or unlikely circumstances as to be of questionable significance?
9. Does the profession have the necessary skills or knowledge to reduce the consequences of the identified harm?
10. What is the distinctive and systematic body of knowledge employed by members of the profession when assessing or treating their patients?
11. What specific academic qualifications does someone require to practice this profession without harm or with minimal harm to patients?
12. What specific on-the-job training must someone undertake to practice this profession without harm or with minimal harm to patients?
13. Is it necessary for the members of a profession to maintain a high level of knowledge and skill and is this level of competency changing so that it is important to upgrade knowledge and skills and be under the review of a governing body?

Before granting an exclusive scope of practice, that scope must be capable of being adequately described so that it can, in turn, be drafted into legislation and have meaning in a court of law.

14. What treatments or services should a member be permitted to perform?
15. What treatments or services should a member not be permitted to perform?
16. What treatments or services should a non-member be permitted to perform?
17. What treatments or services should a non-member not be permitted to perform?

Granting title protection only after the issues regarding scope of practice have been resolved keeps the focus on protecting the public from preventable harm, rather than on the profession's self-interest. However, there may be compelling reasons to grant only the right to use an occupational title. This grant provides a profession with the limited right to call itself a regulated profession.

18. What specific title or initials does the profession wish to protect?
19. Do other professions currently use the same or similar title or initials? Is it a generic title or set of initials? Will the proposed title or initials confuse the public?

If it is decided that a particular title should be restricted or that an exclusive scope of practice should be granted, or both, a series of secondary issues remains to be addressed before granting the profession the full right to self-regulation.

20. Does the applicant represent a majority of people currently practicing in that profession?
21. Is there a sufficient number of members and are they in a financial position to permit the establishment of a separate college or association without financial or other assistance from government?

22. Does the applicant have a clear statement of objectives and a plan of how it proposes to represent its members?
23. Has the profession's leadership demonstrated that it is able to distinguish between the public interest and the profession's self-interest? How has it favoured the former over the latter in the past? How will it do so in the future?
24. How will the public benefit by an assurance of initial and continuing competence of the members of the profession?
25. What specific mechanisms will the profession employ to ensure continued competence of its members? For example, will there be examinations every two years for continual licensure or mandatory continuing education courses?
26. What proportion of the members of the profession have the quality of their performance monitored by supervisors in regulated institutions, by supervisors who are themselves licensed professionals, or by licensed professionals who prescribe this profession's services?
27. How would licensing the profession affect the statutory and administrative authority and scopes of practice of previously licensed professions?
28. Will granting the applicant self-regulation status result in a monopoly which will either reduce the quality of services to be provided to the public or inappropriately restrict entry into the practice by other persons or professionals who provide similar or the same services?
29. How have the members demonstrated their willingness to be part of a self-regulated system? Will they continue to be willing to be involved?
30. How will the profession ensure compliance by its members with the Act and its rules and by-laws?
31. Are there a sufficient number of practicing members to staff all the committees of a governing body?
32. Are the members willing to accept the full cost of self-regulation?
33. What specific mechanisms will the profession use to ensure that its complaints, discipline, internal reviews and judicial appeal procedures operate effectively, efficiently, in compliance with the fundamental principles of natural justice, and in accordance with the doctrines of fairness?
34. Will the profession maintain a governing body that is separate from any body acting as its membership promotion association when negotiating fees or wages, or when acting as a political advocate on behalf of its members?
35. If the profession is currently regulated under an alternative regulatory mechanism, why should there be a new mechanism established? How will the alternative mechanism be eliminated or changed?
36. Can the public be more effectively protected by means other than registration or licensure?

PART E: MISCELLANEOUS INFORMATION

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ANALYSIS OF SUBMISSIONS

Several major conclusions emerge from an analysis of the *submissions.
They include:

- overwhelming support for the current system of health care in British Columbia
- demand for the philosophy and funding of the health care system to shift away from its current emphasis on the treatment of illness to a more balanced approach which includes prevention, treatment, support and long-term care
- concern for the needs of people, organizations and health care workers, and for the rights of individuals
- concern about the lack of a system view of the health care system
- concern about the need to shift services to regional levels and closer to peoples' homes
- concern about the loss of control by individuals and communities of the health care services they receive and the conditions that affect their health.

Several other themes were less well represented in the submissions, but may become more important over the next decade. These themes were put forward by a large number of the presenters but were not discussed at length. These include:

- future trends and changes in the health care system
- the decrease in children and youth in our society and the growth of the seniors population
- conflict and conflict resolution.

• *Methodology*

The information used in this analysis comes from two data bases:

- Transcripts of Public Hearings - 954 transcripts covering interviews with groups and individuals.
- Summaries of Public Submissions - 1464 written submissions.

These data bases were searched from ***the bottom up*** using broad ***first level*** concepts such as ***health*** and ***health care.*** This first level search generated over 5,000 concepts.

Each of these first level concepts was then searched and every unique word within ten words on each side of the selected concept was isolated. These *associated* words were then ordered in terms of the frequency with which they were found. This associated words list provided the context of the first level concepts.

• *Thematic Organization*

A number of different axes were identified by this analysis. The structural and services dimension of the health care system axis was chosen because it was the most inclusive, covering:

- the organization and funding of the health care system
- the occupations and governance of the various health care workers
- the services and special groups requiring care.

The limitation of this choice – or any other choice – is that the details and the perspective other axes could provide are missing.

To give a better understanding of the variety of responses and the intensity of the comments made in the submissions to the commission, this summary has been organized into a series of matrices. These matrices show particular relationships within the first level concepts that emerged during the analysis.

The data base is very rich. This summary demonstrates, but does not fully explore, the depth and type of analysis that can be realized by using content analysis. It does not provide the context in which these concepts should be explained, and is merely a sample of the universe of issues which could more fully describe the different views of the major health care interest groups.

For example, the data base could be used to obtain a better understanding of the concept of *health promotion and its relationship to funding and structure, or the distribution of this particular concern in relation to the availability of treatment services. The different views of the interest groups could then be compared to determine how this issue affects each group's view of its role in the health care system in terms of expansion and replacement of other health professions.

The matrices present only a series of answers to major questions posed to the data base. We hope that the data base will be useful to investigators who wish to better understand how different groups view the health care system.

• *Understanding the Matrices*

Each matrix has the theme and issues presented on the left hand side (vertical axis) of the matrix. The major users or interest groups as well as urban and rural concerns are presented along the top (horizontal axis) of the matrix. In each of the cells, the number of presenters expressing concerns about an issue is identified by the first character and the intensity of their concern by the second character. For the number of presenters and intensity of their concerns the characters are:

	# OF SUBMISSIONS	CONCERN
Ḣ	85+ %	very high
H	65-84%	high
M	40-64%	medium
L	20-39%	low
blank	0-19%	no, or few concerns

In this way, a cell containing the code H/M represents a high number of submissions expressing a medium amount of concern about a topic.

Only those cells with a reasonably strong number of participants or level of interest have been been filled in.

The following list of abbreviations identifies user and interest groups along the top of the matrices:

•Hosp	Hospital administrators and similar
•Phys	Physicians, doctors
•Nurs	Nurses and nursing staff
•Heal Supp	Health support professionals including chiropractors, physiotherapists, etc.
•Unio	Unions
•Educ	Educators including primary, secondary, post secondary and researchers
•Nat	Natives and Native organizations
•All Govt	All levels of government including provincial, federal, regional and municipal (not including Native government)
•Comm/Soc	All community and social agencies, not for profit and profit making
•Publ	All individuals and public organizations (many of whom had other affiliations but may or may not have used their title or declared their organizational affiliation)

MANDATE	Hosp	Phys	Nurs	Heal Supp	Unio	Educ	Nat	All Govt	Comm/ Soc	Publ	Urban	Rural
Health Care Act	M/M	M/M	Ḣ/Ḣ	H/H	H/H	Ḣ/Ḣ	H/H	M/M	H/H	H/H	H/H	H/H
Health Promotion Model	M/M	M/M	H/H	M/H		M/H		H/H	M/H	M/H	M/H	M/H

HEALTH PROMOTION	Hosp	Phys	Nurs	Heal Supp	Unio	Educ	Nat	All Govt	Comm/ Soc	Publ	Urban	Rural
individual's responsibility for own health	H/H	M/M	H/H	M/H		M/H		M/H	M/H	M/H	H/H	
public education/lifestyle & prevention			Ḣ/Ḣ	M/H		H/H		M/H	M/H	Ḣ/Ḣ	M/H	
impact of poverty on human health		M/M	M/M		H/H	H/H	Ḣ/Ḣ		H/H	H/H		
support for "Healthy Communities" concept			M/M	M/M					H/H	H/H	H/H	
low level government spending on prevention/promotion		L/H	M/H	M/M	M/H	H/H	Ḣ/Ḣ		H/H	H/H	M/M	
environmental impacts on human health					M/H	M/H	H/H		L/H	H/H	L/M	

STRUCTURE	Hosp	Phys	Nurs	Heal Supp	Unio	Educ	Nat	All Govt	Comm/ Soc	Publ	Urban	Rural
gaps in service							H/H		M/H	M/H		H/H
inefficient/unresponsive/wasteful structure					H/H	H/H						
fragmentation and duplication of services			M/H		H/Ḣ	H/Ḣ					L/M	H/H
lack of integration between ministries	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/M	M/M	M/M	M/M	H/H
decentralization of structure							H/H		H/H	H/H		H/H
centralization of structure	M/H	M/H										
combination of centralization and decentralization					M/H	M/H						
coordination of health services at community level	H/H		M/H	M/H					H/H	H/H	H/H	H/H
facilitate public input in program development					M/H	M/H			H/H	H/H	H/H	H/H

ACCESS	Hosp	Phys	Nurs	Heal Supp	Unio	Educ	Nat	All Govt	Comm/ Soc	Publ	Urban	Rural
staff shortages	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/Ḣ
difficulty of access to services	H/H	H/H	H/H	H/H	H/H	H/H	Ḣ/Ḣ	H/H	H/H	H/H	M/H	Ḣ/Ḣ
fragmentation of service delivery	M/H			M/H	M/H	M/H	H/Ḣ		M/H	M/H		M/H
prohibitive cost of health care for the poor					M/H	M/H	H/H		M/H	M/H		M/H

COSTS	Hosp	Phys	Nurs	Heal Supp	Unio	Educ	Nat	All Govt	Comm/ Soc	Publ	Urban	Rural
imminent funding crisis	H/H	H/H	H/H						M/H	M/H	M/H	M/H
patient-driven costs	H/H	H/H										
improve public education on costs and use of services	H/H	H/H	H/M	H/M	H/M	H/M	H/L	H/H	H/M	H/L		
restrictions on physicians			H/H	H/H	H/H	M/M			M/H	L/M		
salaries versus fees for physicians					L/H	L/H			L/H	L/H		
expense of new / improved technologies			H/H		M/H	M/H			M/H	M/H	M/H	H/M
governments & medical professionals' ability to evaluate ethical issues				H/H	H/H	H/H	H/H		H/H	H/H		

FUNDING	Hosp	Phys	Nurs	Heal Supp	Unio	Educ	Nat	All Govt	Comm/ Soc	Publ	Urban	Rural
support federal control of health standards	H/H	H/H			H/H	H/H			H/H	H/H	H/H	H/H
provincial administration of health care								H/H				
inequities of system for poor and minority groups					H/H	H/H	H/H		H/H	Ḣ/Ḣ	H/H	

FACILITIES	Hosp	Phys	Nurs	Heal Supp	Unio	Educ	Nat	All Govt	Comm/ Soc	Publ	Urban	Rural
over reliance on institutional care	L/L	L/L	H/H	H/H	H/H	H/H		H/H	H/H	H/H	H/H	L/H
focus on community-based/home care facilities	L/L	L/L	H/H	H/H	H/H	H/H	H/Ḣ	H/H	H/H	H/H	H/H	H/H
insufficient long term care for aging population	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/Ḣ	H/H	M/H
skyrocketing costs	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/Ḣ	H/H	H/H
inadequate funding of hospitals/health care facilities	H/H	H/H	H/H	H/H	H/H	H/H			L/H	L/H	M/H	H/H
government cutbacks resulting poor management	H/H		H/H		H/H						L/H	
hospitals competing for donations	H/H											L/H
amend formula for equip. acquisition	H/H	L/H										H/Ḣ
staff shortage / old technology resulting in lower standard of care	H/H	L/H										H/H
need for advanced information systems	M/H											
need for team approach to decision-making			H/H	H/H	H/H	L/H	H/H		H/H	H/H		
diminishing power of hospital boards										M/H		H/H
elected boards vs. appointed boards										M/H		M/M

HEALTH CARE, FAMILY & REPRODUCTIVE HEALTH	Hosp	Phys	Nurs	Heal Supp	Unio	Educ	Nat	All Govt	Comm/ Soc	Publ	Urban	Rural
poverty & violence against women & children		L/H	M/H		M/H	M/H	H/H		M/H	M/H	H/H	H/H
improvement of services for single-parent families			L/H						L/H	L/H	H/H	
improvement of resources and interventions for victims of abuse		L/H	M/H		M/H	M/H	H/H		M/H	M/H	L/H	L/H
recognition of family as basic unit to provide health environment			M/M	L/H	M/L	H/L			L/H	M/M	H/H	H/H
inadequate home care services	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/Ḣ
need for equal access for all women to services		M/H	H/H	M/H	H/H	H/H	H/H		L/H	L/H	M/H	H/H
socio-economic factors as determinants of preventive and reproductive health care		L/M	M/H	L/H	H/H	H/H	H/Ḣ		H/H	L/H	H/H	
causes of infertility/poor reproductive health & poor foetal health		M/H	M/H	L/H	M/H	M/H	H/H		M/M			
need for improved prenatal care		L/H	M/H	L/H	M/H	M/H	H/Ḣ		L/H	L/H	H/H	
need for improved prenatal education		M/H	M/H	L/H	M/H	M/H	H/H		L/H	L/H	H/H	
need to critically assess neonatal intensive care			L/H	L/H		L/H			H/H			
women to have ultimate control over all medical procedures involving their bodies		M/H	M/M	M/M	M/H	M/H			L/H	L/H		

HEALTH CARE PROFESSIONALS	Hosp	Phys	Nurs	Heal Supp	Unio	Educ	Nat	All Govt	Comm/ Soc	Publ	Urban	Rural
physician-dominated decision-making process			H/H	H/H	H/H	M/H			H/H	H/H	H/H	H/H
barriers to access to system					M/H		H/H		M/H	M/H		H/H
under-valued/utilized skills of nurses and other health care professionals			Ḣ/H	H/H						H/H	H/H	
re-evaluation of roles of nurses and other health care professionals			H/H	H/H	M/H	M/H				M/H	H/H	
development of health care teams			H/H	H/H					M/H	M/H	M/H	H/H
increase scope of practice of nurses and other health care professionals			H/H	H/H	M/H	M/H				M/H	H/H	
alternative health care models desired			H/H	H/H	H/H	H/H	H/H		Ḣ/H	Ḣ/Ḣ	H/H	H/H
medical coverage for other health care services			H/H	Ḣ/Ḣ	M/H				M/Ḣ	M/Ḣ	H/H	H/H
Increased need for cooperation and coordination among professionals			H/H	H/H					H/H	H/H	H/H	H/H
concern over decision-making responsibility among health care professionals			M/H	M/H	M/H	M/H	M/H		H/H	H/H		
need for increased staff resources	H/H	H/H	H/H	H/H	H/H	H/H	H/H		H/H	H/H	H/H	H/H
need for cross-cultural training (immigrants and natives)						M/H	H/H		H/H	H/H	M/H	M/H
more continuing education for nurses and other health care professionals			H/H		M/H							
need for increased training to improve health care delivery	L/H	M/H	H/H	M/H	M/H	M/H	Ḣ/H		M/H	M/H		H/Ḣ
concern over nurses' working conditions			H/H		H/H	M/H			M/H	M/H		M/H

NATIVE HEALTH CARE	Hosp	Phys	Nurs	Heal Supp	Unio	Educ	Nat	All Govt	Comm/ Soc	Publ	Urban	Rural
failure of health care system and health care education to date		L/H					H/H		L/H	L/H	L/H	L/H
social dysfunction and poverty as major problems							H/H		L/H	L/H	M/H	H/H
lack of coordination between senior govt's in delivery of services							H/H		L/H	L/H		Ḣ/Ḣ
lack of health care services		L/H					H/H		L/H	L/H		Ḣ/Ḣ
discrepancy in service and delivery between native and non-Native communities		L/H					H/H		L/H	L/H		Ḣ/Ḣ
lack of native involvment in health care planning							H/H		L/H	L/H		
Native people to administer their own health care							H/H		L/H	L/H		Ḣ/Ḣ
drug and alcohol abuse as most pervasive influence on health		L/H					H/H		L/H	L/H		

HEALTH CARE & THE ELDERLY	Hosp	Phys	Nurs	Heal Supp	Unio	Educ	Nat	All Govt	Comm/ Soc	Publ	Urban	Rural
continued access to quality care for elderly	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/Ḣ
care based on social and medical needs	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H	H/H		
need to improve geriatric serivces	H/H	H/H	H/H	H/H	H/H	H/H	H/H		H/H	H/H		
need to restructure institutional health care model	H/H	H/H	H/H	H/H	H/H	H/H	H/H		H/H	H/H	H/H	H/Ḣ
need to imoprove social support services for elderly	H/H		H/H	H/H	H/H	H/H	H/H		H/H	H/H		Ḣ/Ḣ
need for inter-disciplinary health care teams			H/H	H/H	H/H	H/H	H/H		H/H	H/H		Ḣ/Ḣ
need for respite services			H/H	H/H					H/H	H/Ḣ	H/H	H/Ḣ
need for more health care professionals in mentally ill elderly care	H/H	H/H	H/H	H/H	H/H	H/H			L/H	L/H		L/Ḣ
support of euthanasia		M/H	M/H	M/H	M/H	M/H			M/H	M/H	H/H	

MENTAL HEALTH & MENTALLY HANDICAPPED	Hosp	Phys	Nurs	Heal Supp	Unio	Educ	Nat	All Govt	Comm/ Soc	Publ	Urban	Rural
criticism of medical model			M/H	M/H	M/M				M/H	M/H	M/H	M/H
support of health promotion model			M/H	M/H	M/H	M/H		H/H	M/H	M/H	M/H	
inter-ministerial approach needed		M/M				M/H		L/H	M/H	M/H	M/H	
support of community service model			M/M	M/M		M/M			M/H	M/H	M/H	H/H
more culturally sensitive approach to mental health care			M/H				H/H		L/H	L/H		M/H
better access to services for minorities			M/M			M/H	H/H		L/H	L/H	M/H	
new legislation to protect mentally handicapped					M/H	M/H			M/H	M/H		
lack of care and treatment for mentally handicapped									H/H	M/M		
support for deinstitutionalization			M/H	M/H	L/H	L/H	L/H	L/M	M/H	M/H		M/Ḣ

* GLOSSARY

GLOSSARY

A

ACUTE CARE Care or treatment for illness or injury, usually of short duration, requiring concentrated attention by health care workers.

AMBULATORY CARE Care provided to a patient outside of the patient's home that does not require admission to a health care facility.

ANATOMICAL PATHOLOGY The branch of medicine specializing in surgical pathology (*see below*), the performance of autopsies and the study of disease at the cellular level.

C

CAPITATION An alternative to fee-for-service funding for health care workers, usually physicians, that is based on an annual fixed-sum payment for the provision of a range of services to a specified population with a specified age-sex distribution.

CLINICAL CHEMISTRY Medical or laboratory biochemistry. Blood chemistry and urinalysis fall within the field of clinical chemistry.

COMMUNITY CARE Non-institutional care, including services such as home care, outpatient clinics and adult day care, that is provided in the patient's community.

CONTINUING CARE The Continuing Care Division is a division of the Ministry of Health providing i) institutional and community long-term care for people with chronic illness or disability, and ii) care for people with acute care needs which can be met at home.

CYTOLOGY The branch of laboratory medicine concerned with the study of cells and diseases at the cellular level.

E

EXCLUSIVE SCOPE OF PRACTICE A scope of practice (*see below*) that is the exclusive domain of a specific profession. For example, the practice of medicine is defined in the exclusive scope of practice granted to physicians.

EXTENDED CARE Care provided for people with severe chronic illness or disability requiring 24 hour professional nursing services and continuing medical supervision. Extended care excludes care provided in acute or rehabilitation facilities.

F

FAMILY CLASS IMMIGRANTS Spouses, fiancees, unmarried children under 21, parents and grandparents sponsored by a Canadian citizen.

FEDERAL EXCHANGE-OF-SERVICE An informal federal/provincial arrangement to provide reciprocal public health nursing services to certain Native and non-Native communities by drawing on both federal and provincial nursing resources.

FEE-FOR-SERVICE Payment of a specified fee for a defined unit of service according to a negotiated fee schedule.

FULL-TIME EQUIVALENT (FTE) To provide a common base for staffing and budgetary purposes, the term FTE is used to denote a *position* staffed for 75 hours in every two week period throughout the year. Thus, ten seven-days-per-week LPN *positions* may require fourteen FTEs to provide the necessary coverage.

G

GLOBAL BUDGET A budget that allocates to a hospital, or program, a total amount of funding but does not specify how the money is to be distributed. A global budget provides more internal discretion than a line-by-line budget.

H

HAEMATOLOGY The branch of laboratory medicine specializing in blood cells and blood products.

HEALTH DETERMINANTS The factors – including environmental, social and economic factors – that influence health and determine health status.

HEALTH GOALS Goals for improvements in health status that are stated in measurable terms and incorporate a time scale for achievement.

HEALTH OUTCOME The effects of health care on individual health.

HEALTH PROMOTION The process of enabling people to increase control over the determinants of their health.

HEALTH STATUS The state of health of a group or community. Health status indicators include rates of illness and death, life expectancy and potential years of life lost.

HEALTH UNIT A geographical area used in health services planning and administration. The province is divided into 21 health units.

HOME CARE A comprehensive range of professional nursing services and essential housekeeping services provided in the patient's home.

HOMEMAKER SERVICES Services provided in the home to people who require non-professional personal assistance with care or with essential housekeeping tasks.

HOME NURSING CARE Professional nursing services provided in the patient's home.

HOSPITAL SEPARATIONS The total number of patients discharged from hospital *plus* the number of deaths occurring in hospital.

I

IMMUNOLOGY The branch of laboratory medicine specializing in the response of the body's biological defence system.

INDEPENDENT IMMIGRANT CLASS Immigrants selected by the "points system," which measures the potential for successful establishment in Canada.

I

INFORMED CONSENT A patient's consent to treatment given after the nature and possible consequences of that treatment have been explained.

INPATIENT CARE Care requiring admission to a hospital or other health care facility for a stay of at least twenty-four hours.

INTERMEDIATE CARE Care provided in long-term care facilities for people that require professional nursing care and assistance with the activities of daily living. The three levels of Intermediate Care – IC1, IC2 and IC3 – involve progressively more care and assistance.

INTRAVENOUS (IV) ADMIXTURE SYSTEM A hospital pharmacy based system in which all IV medications are mixed in the pharmacy department under sterile conditions.

L

LANDED IMMIGRANT An immigrant who has been granted permission under the law to enter Canada and establish permanent residence.

LIFESTYLE-ASSOCIATED DISEASES Diseases caused by, or strongly associated with, lifestyle choices, e.g., alcoholism caused by chronic heavy drinking; sexually transmitted diseases associated with sexual promiscuity.

LOCAL HEALTH AREA The smallest geographical area used in health services planning and administration. The province is divided into 80 local health areas.

LOCUM (TENENS) A physician who temporarily substitutes for another physician.

LONG TERM CARE Institutional or community care provided for people with chronic illness or disability.

M

MATRIX ORGANIZATION An organization structure in which members have a dual allegiance – to a particular assignment or task, and to their departments. For example, a regional coordinator for continuing care might report both to Institutional Services *and*, locally, to a regional general manager.

MODIFIED RELEASE DOSAGE A solid drug that has been modified to alter the rate at which the active agent is released into the body.

MODIFIED UNIT DOSE SYSTEM A drug distribution system in which medications are dispensed in individually labelled, controlled dosage cards or containers. Each drug is dispensed as one card for each scheduled dosage time.

MORBIDITY Illness, injury or disability.

MULTI-LEVEL CARE FACILITY A long-term care facility that provides service to both Intermediate Care and Extended Care residents.

N

NEONATAL PERIOD The first 28 days of life of the newborn child.

NURSE PRACTITIONER A registered nurse specifically trained and educated to provide primary care. Diagnosis and treatment are included in the scope of practice. Nurse practitioners usually work under the general supervision of a physician, but do not necessarily require a physician's presence to practice.

O

OFFSHORE SELECTION PROCESS The selection of immigrants in the country of origin.

P

PALLIATIVE CARE Compassionate, interdisciplinary care for the terminally ill, that aims to comfort and support the patient and family through the process of dying by addressing physical, psychological, social, spiritual and economic needs.

PATHOLOGIST A physician specializing in the essential nature of disease and in the detection and description of changes in tissue or function associated with disease.

PERINATAL PERIOD The period surrounding birth. Usually from the 28th week of gestation to the 28th day of life of the newborn child.

PERINATOLOGIST A physician specializing in problems associated with the final phase of pregnancy and the early life of the newborn child.

PERSONAL CARE The least intensive level of long-term facility care; for people who are independently mobile and require minimal, non-nursing care and assistance with the activities of daily living.

PRENATAL During the period of pregnancy.

PREVENTABLE DISEASES Diseases which may be prevented from developing or spreading by taking specific precautionary actions; e.g. diseases prevented by immunization.

PRIMARY CARE Care provided by a health care worker on a patient's first contact with the health care system. Primary care may include referral to more specialized levels of care.

PROPHYLAXIS The use of measures or devices preventing the development or spread of disease.

PSYCHOTROPIC DRUGS Drugs that affect mental state.

PUBLIC HEALTH NURSING Public health nurses are employed directly by the Ministry of Health and have responsibilities that may include health promotion, health protection, health education and primary care.

Q

QUALITY ASSESSMENT The comparison of standards of performance for care with observed performance.

QUALITY ASSURANCE The processes of setting quality standards for care, comparing actual performance with those standards and acting to ensure that the standards will be met.

R

REFUGEE AND DESIGNATED CLASSES Immigrants meeting the definition specified by the United Nations Refugee Convention *and* people assessed under relaxed immigrant selection criteria.

REGIONAL HOSPITAL DISTRICT A geographical area used in hospital services planning and administration. The province is divided into 30 regional hospital districts.

S

SCOPE OF PRACTICE The protocols that define what acts may be performed under what circumstances by specified health care personnel.

SECONDARY CARE Care provided by a specialist health care professional, such as a psychiatrist or general surgeon, on referral from a primary care physician.

SINGLE SOURCE DRUG PRODUCTS Drugs, usually under patent protection, which have a single source of manufacture and no generic equivalent.

SUBMISSIONS Written or orally presented material placed before the commission for inclusion in the commission's deliberations.

SURGICAL PATHOLOGY The examination of tissue from surgical procedures, including biopsies, for signs of disease.

T

TEACH AND BLEACH An AIDS prevention protocol for IV drug users involving the use of chlorine bleach to sterilize syringes and needles.

TERTIARY CARE Care that requires highly specialized skills, technology and support services. Usually provided in facilities serving a large region or the province as a whole.

TRIAGE Medical screening of large numbers of patients to determine priority for treatment. Patients are usually classified by the triage process into one of three categories: emergent, urgent and non-urgent.

U

UNIT DOSE SYSTEM A drug distribution system in which medications are dispensed from a hospital pharmacy in a unit of use (i.e., one dose) for each time the medication is to be administered in a 24 hour period.

UTILIZATION MANAGEMENT Setting standards for the efficient use of care resources, comparing the observed use of resources with those standards and *acting* to ensure that standards will be met.

UTILIZATION REVIEW Comparing standards for the efficient use of care resources with the observed use.

V

VIROLOGY The branch of microbiology which is concerned with viruses and viral diseases.

W

WEIGHTED PATIENT DAYS An approximate measure of hospital workload, used for funding purposes, that converts hospital length-of-stay in acute or intensive care and inpatient or day care surgical procedures to a common base of a standard inpatient day.

Z

ZERO BLOOD ALCOHOL TOLERANCE A policy that would make it illegal to drive with a detectable level of alcohol present in the bloodstream.

E14

HISTORY AND HEALTH CARE: A BRIEF LOOK AT BC

The following history has been compiled from a large number of sources. Its focus is the establishment and opening of hospitals and health units and it is by no means complete. We hope that it will give the reader an idea of the growth of the health care system and contribute some information to those people with an interest in building a detailed history of the province.

Evidence of human habitation dates back thousands of years in BC. The Native British Columbians who built these early sites lived in complex and successful societies in which self-esteem and caring played an important part. Very little is known about their health or health care prior to European contact, but the practices preserved today in a number of communities speak of a rich tradition

1778
- Captain James Cook makes landfall at Nootka Sound.

1789
- Frances Hornby Trevor Barkley is the first recorded non-Native woman to arrive in BC.

1790
- The Nootka Convention gives Spain and Great Britain equal trading rights along the North Pacific Coast.

1792
- Captain George Vancouver circumnavigates Vancouver Island and undertakes the first detailed survey of the Pacific Northwest Coast.

1805
- Simon Fraser establishes Fort McLeod, now the oldest surviving non-Native community in BC.

1806
- Simon Fraser establishes Fort Fraser and Fort St. James.

1807
- Simon Fraser establishes Fort George (later to become Prince George).
- David Thompson establishes Kootenae House near Lake Windermere.

1827
- Fort Langley founded by the Hudson's Bay Company.

1843
- Fort Camosun, later named Fort Victoria, founded on Vancouver Island by the Hudson's Bay Company.

1846
- The Oregon Treaty sets the boundary between the Colony of British Columbia and the United States.

1849
- Great Britain establishes a colony on Vancouver Island.

1850
- Dr. John Sebastian Helmcken, the first medical practitioner in BC, arrives on Vancouver Island.
- A young Scottish immigrant is diagnosed with the earliest recorded case of mental illness. He apparently recovers from his illness on the voyage home.

1851
- George Langford, born in the governor's residence, is recorded as the first non-Native person born on Vancouver Island.

1852
- Nanaimo is founded. The Hudson Bay Company begins mining coal in the only known coastal coal field north of Chile.

1855
- Hospital huts are set up in Esquimalt by the British Navy.

1858
- The Colony of British Columbia is established with Fort Langley as the capital.
- Four Sisters of Saint Ann arrive in Victoria from Quebec to teach and to visit the sick. Sister Mary of the Sacred Heart, Sister Mary Angele, Sister Mary Lumena and Sister Mary Conception live in a small log cabin on the edge of what is now Beacon Hill Park. This cabin becomes the first convent school in the Canadian West.

- The Royal Hospital opens at a temporary site by Yates and Broad Streets in Victoria. A cottage, it admits only men for the first six years.
- The Fraser River gold rush begins.
- The first recorded Chinese arrives from California.

1859
- New Westminster supersedes Fort Langley as the capital of the Colony of BC.
- William Fraser Tolmie, a surgeon, fur trader and politician, arrives in Victoria and builds the colony's first recorded stone house.

1860
- The Cariboo gold rush begins.
- The French Hospital is opened in Victoria for members of the French Benevolent and Mutual Society.

1862
- The City of New Westminster inherits the disbanded Royal Engineers' Camp Hospital and reopens it as the Royal Columbian Hospital, making it the first public hospital on mainland BC.
- Fort Victoria is incorporated as the city of Victoria.
- A smallpox epidemic kills an estimated 20,000 Natives out of a total population of about 60,000. Approximately two-thirds of the Tsimshian people of BC die.
- Dr. Helmcken begins vaccinations for smallpox in the province.
- Canada's first Chinese Masonic Temple is built in Barkerville. The building serves as a temple, employment bureau, funeral home and medical clinic.
- Rose Schubert, born at Fort Kamloops, is the first non-Native birth recorded in the Interior.

1863
- Dr. Cheadle is the first doctor to practice in Kamloops. His practice includes many Canadian Pacific Railway workers.
- Following an outbreak of typhoid at Williams Creek, the miners petition for and get a three-room log hospital, The Royal Cariboo Hospital, at Maryville.

1866
- Great Britain unites British Columbia and Vancouver Island.

1867
- Canada becomes a nation. The Constitution Act gives the provinces the responsibility for providing their own health care services.

1868
- Victoria is named the capital of the United Colony of British Columbia.
- The federal government passes the Indian Act.

1869
- To upgrade health standards an "ordinance for promoting public health in the colony of British Columbia" is passed.

1871
- British Columbia becomes a province of Canada.

1872
- An Act Respecting the Registration of Births, Deaths and Marriages in the Province of British Columbia passes. It excludes Native British Columbians and Chinese.
- The Royal Hospital, a sometimes "pest house" for male mental patients unable to be housed in the local gaol, is taken over by the province as the Provincial Lunatic Asylum.

1873

- The Insane Asylums Act is passed and places management of the Provincial Lunatic Asylum under medical and non-medical superintendents, both of whom report to the provincial secretary.

1874

- Chinese and Native peoples are disenfranchised by the provincial government.

1876

- The Sisters of Saint Ann open St. Joseph's Hospital in Victoria.
- Victoria General Hospital opens.

1877

- Dr. W.W. Walkem arrives at Hastings Mill. His contract is made up of two parts: the major part is a flat fee of $1 a month paid by each of the employees of Hastings Mill and the 250 employees of Moody's Mill; the minor part is an honorarium of $100 a year from the provincial government for acting as coroner.
- The Provincial Lunatic Asylum moves, with its 38 patients, to the present Woodlands site.

1881

- Nanaimo Hospital opens on the west side of Chapel Street, Nanaimo.

1882

- A Chinese leper, the first reported case of leprosy in BC, is hanged in New Westminster in an attempt to stop the spread of the disease.
- A branch of the Women's Christian Temperance Union starts in Victoria.

1884

- Federal legislation outlaws the potlatch and makes the practice a misdemeanour subject to imprisonment.

1885

- The Royal Inland Hospital, Kamloops, opens.

1886

- Vancouver is incorporated as a city in April and destroyed by fire two months later.
- The Medical Act establishes the College of Physicians and Surgeons of BC.
- The CPR reaches Port Moody.
- The CPR opens the nine bed Railway Hospital in a tent beside the railway right-of-way north of Powell Street near Hawkes and Heatley Avenues. The City of Vancouver takes over the operation of the Railway Hospital in September.

1887

- The Canadian Pacific Railway reaches Vancouver.
- The Sisters of Charity of Providence open St. Mary's Hospital, New Westminster.

1888

- Vancouver opens its first general hospital. The new City Hospital is a two-storey, 35 bed, wooden building on Beatty Street, south of Pender, facing Cambie Street.
- An Act Respecting the Registration of Births, Deaths and Marriages in the Province of British Columbia is amended to include Chinese and Natives.

1889

- The Capilano River watershed begins supplying Vancouver with water.

1890

- The 48 bed Provincial Royal Jubilee Hospital is opened in Victoria. It replaces the Royal Hospital and the French Benevolent Society Hospital and is available "... to the citizens of Victoria and of the province of BC."

1891

- The first training school for nurses in BC opens at the Royal Jubilee Hospital, Victoria. Six students enrol for a two year program.
- Five lepers are quarantined on D'Arcy Island, just east of the Saanich Peninsula, Vancouver Island.

1892

- Smallpox epidemic in Vancouver and Victoria. Dr. J.C. Davie is appointed to enforce sanitary regulations to meet the emergency.
- Dr. A.E. Bolton opens a hospital with the aid of the Women's Missionary Society at Port Simpson at the mouth of Nass River. The hospital later opens branch hospitals at Rivers Inlet and at Port Essington.

1893

- An operating theatre is added to Vancouver's City Hospital.
- Mary MacNeill of Victoria, a graduate of Women's Medical College, Chicago, is registered as the province's first woman physician.
- City Hospital adds a separate operating theatre.
- An Act to provide for the establishment and maintenance of a Provincial Home for the Aged and Infirm is passed. It excludes Natives, Asiatics, habitual drunkards and those with mental or other "... contagious, infectious or loathsome disease".
- Golden and District General Hospital and Kootenay Lake District Hospital, Nelson, open.
- St. Bartholomew's Hospital, Lytton, opens.

1894

- Sisters of Providence open the 25 bed St. Paul's Hospital in Vancouver.

1895

- The Victoria Medical Society holds its first meeting. Eighteen members attend.
- A Provincial Home for Aged Persons is opened in Kamloops in September. The first superintendent is Joseph Ratchford.
- Cumberland Health Centre opens on Vancouver Island.
- The world's first x-ray photograph is made.

1896

- There is a serious outbreak of typhoid fever in the Kootenay district. Mr. C. Phillips Woolley is appointed provincial sanitary inspector.
- The Sisters of St. Joseph, Newark, open Mater Misericordiae Hospital, Rossland.
- Provincial regulations are issued regarding smallpox, cholera, scarlet fever, diphtheria and disinfection.

1897

- Dr. F. Underhill is appointed the first provincial bacteriologist.
- The Provincial Lunatic Asylum is renamed The Public Hospital for the Insane.
- The Hospitals for the Insane Act passes and supersedes the Insane Asylums Act.
- The Victorian Order of Nurses (VON) is founded in Ottawa.

1898

- The Vancouver Medical Association holds its first meeting.
- New Westminster is badly damaged by fire.
- The first BC branch of the VON is established in Vancouver.
- The Sisters of Providence open St. Eugene Hospital, Cranbrook.

1899

- Dr. C.J. Fagan is appointed secretary of the provincial Board of Health and becomes the first permanent medical health officer.
- The first x-ray in the province is taken at Royal Jubilee Hospital, Victoria.
- Chemainus Hospital opens.

1900

- The Women's Missionary Society open St. Andrew's Hospital, Atlin.
- The Presbyterian Mission is used as temporary hospital in Hazelton.
- Peterborough, East Kootenays, now known as Wilmer, opens a hospital.
- The first ambulance north of Portland, Oregon, is purchased by the Vancouver Coal Company for use in Nanaimo.

1901

- The VON open the Queen Victoria Memorial Hospital, Vernon.

1902

- The Vancouver General Hospital is incorporated.
- The United Church opens Wrinch Memorial Hospital in Hazelton.
- The Victorian Hospital, Kaslo, Queen Victoria Hospital, Revelstoke, and the R.W. Large Memorial Hospital, Bella Bella open.

1905

- Consolidated Mining and Smelting (later COMINCO) in Trail provides its workers with company sponsored medical care.
- The province assumes responsibility for the D'Arcy Island lepers.
- Columbia I, the first of eleven Columbia Coast Mission hospital ships to ply the west coast, is launched from Wallace Shipyard, False Creek, Vancouver.
- The Columbia Coast Mission opens Queen's Hospital at Rock Bay.

1906

- The new Vancouver General Hospital opens on Fairview slopes.
- Prince Rupert is founded by Grand Trunk Pacific Railroad.

1907

- D'Arcy Lazaretto, a leprosarium, is established on D'Arcy Island.
- The Tranquille Sanatorium is established in Kamloops by the British Columbia Anti-tuberculosis Society.
- The St. Paul's Hospital Training School for nurses is established. Fourteen women attend the first class.
- The Columbia Coast Mission opens Columbia Hospital on Texada Island.
- The VON opens a hospital in Fernie.

1908

- The Fernie hospital burns down.
- Misses Mina and Jenny Dawson, and their sister Mrs Stevenson, open the first North Vancouver Hospital.
- Armstrong-Spallumcheen Hospital, Armstrong, Queen Charlotte Islands General Hospital and Kelowna General Hospital open.
- Chilliwack is incorporated.

1909

- The Columbia Coast Mission opens St. Georges Hospital in Alert Bay.
- Prince Rupert Regional Hospital and Summerland General Hospital open.

1910

- The legislature passes an act to provide for the medical inspection of children in schools throughout BC.
- The Quesnel Hospital opens but, due to difficulties in obtaining staff, the first permanent physician, Dr. G.R. Baker, does not arrive until 1912.
- The second North Vancouver Hospital opens. This 15 bed hospital is the first facility in North Vancouver designed to be used as a hospital.

- Victoria partially destroyed by fire.
- Prince Rupert incorporated as a city.
- The Victoria Branch of the VON established.
- Ladysmith General Hospital and Stewart General Hospital open.
- The Emergency VON Hospital opens in Chase. This is taken over by the Adams River Lumber Company in 1918.
- Queen's Hospital, Rock Bay, burns down.

1911
- The 25 bed St. Michael's Hospital is built by the Columbia Coast Mission at Rock Bay.
- The Provincial Department of Vital Statistics is formed. Previously Vital Statistics was administered by the Registrar under the authority of the Attorney-General.
- Chilliwack General Hospital, Cowichan District Hospital, Chemainus, and Princeton General Hospital open.
- The King's Daughters Hospital, Duncan, opens.

1912
- Vancouver General Hospital establishes a Department of Social Service, the second of its kind in a Canadian hospital.
- West Coast General Hospital, Port Alberni, opens.
- Burnaby and North Vancouver Branches of the VON are established.

1913
- Essondale, named after the Provincial Secretary, Dr. Henry Esson Young, opens. Initially, it is used "... to house the overflow from the Public Hospital for the Insane".
- Miss Blanche Swan (Lewis) is appointed the first provincial school nurse.
- The first Provincial Health Laboratory established in Victoria.
- St. Joseph's General Hospital, Comox, is established by the Sisters of St. Joseph from Toronto.
- Penticton Regional Hospital, Lady Minto Cottage Hospital, Ashcroft and Shuswap Lake General Hospital, Salmon Arm, open.

1914
- World War I. Over the next four years, 55,570 British Columbians from a population less than 450,000, go to war. Six thousand, two hundred and twenty-five die, over 13,000 are wounded.
- VON opens Lady Minto Gulf Islands Hospital, Ganges.
- Invermere opens a hospital which, in 1917, is replaced by a VON hospital called Lady Elizabeth Bruce Memorial Hospital.
- The Campbell River Hospital opens.

1915
- Shaughnessy Hospital opens.

1916
- Dr. Young is appointed Secretary of the Provincial Board of Health, Registrar-General of Births, Deaths and Marriages and provincial health officer. He serves until his death in 1939. He is generally remembered as the father of public health in BC.
- Legislation allows BC Natives to have births, deaths and marriages registered, as a separate unit, with the province.
- 20 lepers are quarantined on Bentick Island, southwest of Sooke, Vancouver Island.

1917

- The Workmen's Compensation Act is passed.
- The province begins registering Native births.
- Women are enfranchised.
- Dr. Malcolm MacEachern organizes The British Columbia Hospitals' Association, Canada's first hospital association.
- Enderby and District Memorial Hospital and Lady Elizabeth Bruce Hospital, Invermere, open. The Invermere hospital is later renamed Windermere District Hospital.

1918

- Prohibition begins in Canada.
- The Quesnel hospital is enlarged.
- The Spanish influenza reaches BC. The Heather Street Annex of the Vancouver General Hospital is built to house victims of the epidemic. Thirty thousand Canadians die.
- The Nurses' (Registered) Act incorporates the Graduate Nurses Association of BC.
- Prince George Regional Hospital opens and the R.W. Large Memorial Hospital expands and takes over the Rivers Inlet Branch of the Port Simpson Hospital.
- World War I ends.

1919

- The Burnaby Branch of the VON receives its first car, a Model-T Ford.
- The Saanich War Memorial Centre, the first provincial health centre, is established in Saanich. It is financed through local taxes and grants from the Provincial Board of Health. Miss Jessie Foreshaw is appointed as the first public health nurse at Saanich.
- The University of British Columbia starts the first university degree program in nursing in the British Empire.
- BC suffers a diphtheria epidemic.
- A hospital opens in Kimberly.
- The Burns Lake and District Hospital opens.

1920

- BC repeals prohibition.
- The Cowichan Health Centre and the Rural Esquimalt Health Centre, Langford, open.
- Bulkley Valley District Hospital, Smithers, opens.
- St. Charles ether apparatus, an ether vaporizer for anaesthetics invented by Sister Charles Spinola of St. Paul's Hospital, is patented.

1921

- The province purchases Tranquille Sanatorium from the British Columbia Anti-tuberculosis Society.
- The BC Royal Commission on Health Insurance.

1921

- Prohibition ends in the whole of Canada.

1922

- A team of Canadian researchers, F. Banting, C.H. Best, J.J.R. Macleod and J.B. Collip, discover insulin.
- The province changes to driving on the right-hand side of the road.

1923

- St. George's Hospital, Alert Bay, is destroyed by fire.
- The 16 bed Children's Hospital opens in Vancouver.
- The Campbell River Hospital closes for lack of funds.
- The G.R. Baker Memorial Hospital, Quesnel, opens.
- Mission Memorial Hospital, Mission, and Arrow Lakes Hospital, Nakusp, open.

1925
- The Royal Cariboo Hospital at Maryville closes.
- Bella Coola General Hospital opens.

1926
- Fernie District Hospital and Trail Regional Hospital open.
- Slocan Community Hospital and Health Care Centre opens.
- The Sisters of St. Anne rehabilitate the hospital in Campbell River and rename it Our Lady of Lourdes Hospital.

1927
- The Salvation Army's Grace Hospital and an enlarged Children's Hospital, Vancouver, open.
- The Old Age Pensions Act is passed by the federal government. British Columbia is the first province to pass enabling legislation.
- Kimberly and District Hospital opens on the 1922 hospital site.

1928
- Canada's first accredited School of Dietetics is established at Vancouver General Hospital.
- South Okanagan Health Unit in Kelowna is established.
- Creston Valley Hospital opens.

1929
- Vancouver extends its boundaries to include the municipalities of Point Grey and South Vancouver making it the third largest city in Canada.
- Stock market collapse heralds the beginning of the Great Depression, Canada's "ten lost years."
- The 65 bed North Vancouver General Hospital is opened.

1930
- Dr. L. E. Borden introduces a bill in the legislature limiting the use of the title "doctor" to members of the medical profession. The bill passes unanimously.
- The Columbia Coast Mission opens St. Mary's Hospital in Garden Bay, Pender Harbour.

1931
- Sunny Hill Hospital for Children, Vancouver, opens.

1932
- Dawson Creek and District Hospital opens.
- Fort St. John General Hospital opens.

1935
- Peace River Health Unit in Dawson Creek is established.
- Tofino General Hospital opens.
- An "Act to provide for the Establishment and Maintenance of a Provincial Home for Aged Persons" is passed and the provincial secretary is charged with its administration.

1936
- A new tuberculosis hospital, the present Willow Chest Centre on the Vancouver General Hospital site, opens.
- BC's first health insurance legislation, "An Act to provide for a Provincial System of Health Insurance", is passed. A Health Insurance Commission is established but runs into opposition while attempting to administer the Act and the Act is never implemented.

1937

- Miss McPhee and Miss Rodd leave for Kyuquot on the west coast of Vancouver Island to staff a new Red Cross hospital outpost.
- Vancouver receives the world's first iron lung to be used in the treatment of polio.
- The Vancouver Metropolitan Health Department is established.
- The Elphinstone Branch of the VON is established.

1938

- The Provincial Royal Jubilee Hospital is renamed the Royal Jubilee Hospital.
- The Surrey Branch of the VON is established.

1939

- World War II begins. Over the next five years, 90,456 British Columbians from a population of approximately 800,000, go to war. Three thousand seven hundred and eighty-four die.
- The Sisters of Charity of the Immaculate Conception, Saint John, New Brunswick open St. Vincent's Hospital, Vancouver.

1940

- BC has 44 Provincial public health nurses and Miss Heather Kilpatrick is appointed the first director of public health nursing.
- A Medical Services Association plan for group medical, surgical and hospital treatment of workers is announced. It is designed to provide medical and surgical services to employees in groups of 10 or more at a cost of 3 1/2 cents a day.
- The West Vancouver Branch of the VON is established.

1941

- The Sisters of Saint Ann open Mount St. Mary's Hospital, Victoria.
- St. John's Hospital, Vanderhoof, opens.
- Colqualeetza Indian Hospital opens at Sardis in Fraser Valley.

1942

- The Alaska Highway links Dawson Creek with the Yukon Territory and Alaska.
- Skeena Health Unit, Terrace, and Powell River General Hospital open.
- The Trail Branch of the VON is established.
- The Sisters of St. Ann open St. Martin's Hospital, Oliver.

1943

- Canadian National Steamships' Lady Nelson is converted to Canada's first armed forces hospital ship. The vessel can accommodate 200 walking wounded and 300 lying-in patients. The vessel has nine medical officers, 14 nursing sisters and 60 other ranks.
- Privately operated hospital insurance begins in BC. North Vancouver General Hospital is the first hospital in the Lower Mainland to officially approve of the plan.
- The Central Vancouver Island Health Unit is established in Nanaimo.

1944

- The War session at the American College of Surgeons meeting at the Hotel Vancouver is told by one United States Army doctor that "... we don't like to paint too optimistic a future for penicillin".
- Mobile x-ray surveys start in both rural and urban areas.
- The North Okanagan Health Unit, Vernon, is established.

1945
- World War II ends.
- A Canadian-developed drug, heparin, is hailed for reducing the need for amputation.
- The first Red Cross Blood Transfusion Service in BC is started at St. Joseph's Hospital, Victoria.

1946
- The Vancouver General Hospital establishes one of the first Respiratory Services (oxygen therapy department) in North America. The department is important in the development of both a nebulizer (misting breathing aide) and the infant oxygen hood.
- Mount St. Joseph's Hospital, Vancouver, opens.

1947
- The East and West Kootenay Health Units are established in Cranbrook.
- Holy Family Hospital, Vancouver, opens.

1948
- The Hospital Insurance Act is passed, making hospital care available to all residents.
- Four new public health nursing districts open: Castlegar, Invermere, Burns Lake and the North Thompson district.
- Northern Interior Health Unit in Prince George is established.
- Langley Memorial Hospital and Lillooet District Hospital open.

1949
- A progress report on the provincial BC Hospital Insurance Service comments that 94 percent of the population of British Columbia is being served by public health nursing services. The report further states that public health nurses have been the "... spearhead of the local public health movement in BC"
- The Hope-Princeton Highway opens.
- The University of British Columbia undertakes to organize a faculty of medicine and a decision is made to use old army huts until the first permanent building is finished. Dr. Myron Weaver is appointed dean of the new UBC medical school.
- The Crease Clinic of Psychological Medicine, "... intended as an active treatment centre for the attack upon mental illness in its early phases", is opened. The first patients are admitted in 1950.
- The Upper Island Health Unit in Courtenay and Upper Fraser Valley Health Unit in Chilliwack are established.
- The G.F. Strong Centre for rehabilitative medicine, Vancouver, opens.
- Vernon Jubilee Hospital replaces the Queen Victoria Memorial VON Hospital.

1950
- A medical faculty is established at the UBC.
- The Mental Hospitals of BC are reorganized into the Provincial Mental Health Services.
- The Public Hospital for the Insane is renamed The Woodlands School in recognition of its educational role.
- The West Kootenay Health Unit in Trail, Central Fraser Health Unit in Maple Ridge and the Simon Fraser Health Unit in New Westminster are established.

1951
- The national census shows that BC's population has increased by 42 percent from 1941-1951. The increase places a considerable strain on all services, including health services.
- A new federal Old Age Security Act replaces the 1927 Act. The new Act grants pensions to people 70 years of age and over without a means test and is paid entirely by the federal government.
- Mills Memorial Hospital, Terrace, opens.
- The federal government conducts a national Sickness Survey

1952

- UBC's medical school graduates its first class.
- South Central Health Unit in Kamloops and Boundary Health Unit in Cloverdale are established.
- Burnaby Hospital, the George Pearson Centre, Vancouver, and Squamish General Hospital open.

1953

- The Selkirk Health Unit, Nelson, and Pouce Coupe Community Hospital open.
- The Armstrong-Spallumcheen Health Centre opens.

1954

- Hospital insurance premiums are stopped and BC's hospital insurance plan begins to be financed out of general provincial revenues.
- McBride and District Hospital, McBride, Gorge Road Hospital, Victoria, and Peace Arch District Hospital, White Rock, open.

1955

- Prince George becomes the first city in BC to fluoridate its water supply.
- Salk vaccine for immunization against polio is introduced in the province.
- An Act to Amend the Provincial Home Act of 1935 is passed. Wording of the Act replaces 'Provincial Secretary' with 'Minister of Health'. Race, colour or creed are no longer criteria for entering a provincial long term care facility, and elderly males no longer need to be destitute before being admitted.

1956

- Seventy percent of the school population has been immunized against diphtheria since the 1919 outbreak and by 1956 there is only one reported case in the province.

1957

- The Hospital Insurance and Diagnostic Services Act, which gives the federal government the authority to arrange with each province a plan to cover acute hospital care and laboratory and radiology diagnostic services, is enacted.
- Campbell River and District General Hospital, Campbell River, opens.

1958

- The Tranquille Sanatorium in Kamloops is no longer needed as a hospital for tuberculosis patients. The physical plant is transferred to Mental Health Services.

1958

- The Hospital Insurance Program begins in BC, Alberta, Saskatchewan, Manitoba and Newfoundland.
- Castlegar and District General Hospital, Castlegar, Fort Nelson General Hospital, Fort Nelson, and Maple Ridge Hospital, Maple Ridge, open.
- The Salmon Arm Health Centre opens.

1959

- The number of Provincial Health Nurses in BC rises to 191.
- The Mental Health Services reopens Tranquille School with patients transferred from the Woodlands School.
- The Centennial Pavilion of Vancouver General Hospital opens.
- Fraser Canyon Hospital, Hope, and Surrey Memorial Hospital open.

1960

- Kitimat General Hospital opens.

1961

- The federal government establishes the Royal Commission on Health Services headed by Justice Emmett Hall to "... ensure that the best possible health care is available to all Canadians."
- Lions Gate Hospital, North Vancouver, opens.

1962

- Harold Copp, a researcher at the University of British Columbia, isolates the hormone calcitonin which has the ability to lower blood calcium.
- Oral Sabine Polio Vaccine is introduced in the province.
- The Rogers Pass Highway is opened between BC and Alberta.
- Cariboo Memorial Hospital and the Cariboo Health Unit in Williams Lake are established.
- The Chilliwack Health Centre opens.

1963

- Boundary Hospital, Grand Forks, opens.

1964

- The Royal Commission on Health Services (the Hall Commission) presents the Health Charter for Canadians. The report is the origin of the five principles of medicare.
- The Coast Garibaldi Health Unit in Powell River is established.
- Nicola Valley General Hospital, Merritt, and St. Mary's Hospital, Sechelt, open.

1965

- The BC Medical plan begins.

1966

- 100 Mile District General Hospital, 100 Mile House, and Richmond General Hospital, Richmond, open.

1967

- The operation of the Vancouver General Hospital is transferred from the City of Vancouver to the Greater Vancouver Regional District.
- Mount St. Mary's Hospital becomes an extended care unit.
- Dr. R.L. Noble and Dr. C.T. Beer announce the development of a new anti-cancer drug at UBC. Extracted from periwinkle leaves, the new drug is hailed as one of the outstanding medical discoveries of the decade.
- The federal government passes a Medical Care Act to share the cost of medical insurance plans in each province.

1968

- BC implements the Medical Care Act.
- Cranbrook Regional Hospital and Eagle Ridge Hospital and Health Care Centre, Port Moody, open.
- The UBC Health Sciences Centre opens.

1969

- Canadian Broadcasting Corporation announces the banning of all tobacco advertising on its radio and television networks.
- UBC Hospital Psychiatric Services Hospital opens.

1970

- Rubella vaccine is introduced into the province.
- Chetwynd General Hospital opens.

1971

- McKenzie and District Hospital and the Department of National Defense Base Hospital, Masset, open.

1972

- The Pine Street Youth Clinic, Vancouver, opens.
- The Dr Helmcken Memorial Hospital, Chilliwack, and Port Alice Hospital open.
- Stuart Lake Hospital, Fort St. James, South Okanagan General Hospital, Oliver, and Port Hardy Hospital open.

1973

- Dr. Richard G. Foulkes presents his report on health care in BC, Health Security for British Columbians.
- The Gold River Health Clinic and Tahsis Hospital open.

1974

- The Emergency Health Services Commission is established to provide pre-hospital ground and air ambulance service.
- Responsibility for services for the mentally retarded transfers from the Department of Health to the Department of Human Resources.
- The provincial Pharmacare Program begins.

1975

- The Provincial Home for Aged Persons is closed and patients are transferred to Ponderosa Lodge, an intermediate care facility in Kamloops.

1977

- Comprehensive long-term institutional and at-home health care programs are announced by the BC government.
- The Elkford and District Diagnostic and Treatment Centre and Pemberton and District Diagnostic and Treatment Centre open.
- Overlander Extended Care Hospital, Kamloops, opens.
- The Pharmacare Program is modified to remove age restrictions.
- Delta Hospital, Delta, opens.

1978

- Construction begins on the Children's/Grace Hospital complex at the Shaughnessy site. It is the first complex in North America to accommodate both a children's and a maternity hospital.
- The Home Care/Long Term Care program is started.
- The Fraser Lake Diagnostic and Treatment Centre is established.
- Saanich Peninsula Hospital, Saanichton, and Sparwood General Hospital open.

1979

- A Royal Commission of Inquiry into Uranium Mining in British Columbia is initiated.

1980

- Justice Emmett Hall reports on health care in Canada to the federal government.
- A seven year moratorium on uranium exploration and mining begins in BC.
- UBC Hospital general public services opens.

1982

- All newborn, paediatric and obstetric services are transferred from Vancouver General Hospital to the new Children's/Grace Hospital.
- BC Medical Plan coverage is extended to all pregnant women 35 and older who ask for amniocentesis, a test to detect possible birth defects.

1983

- The first AIDS case in BC is described and the province becomes the first North American jurisdiction to make AIDS a reportable disease. By the end of 1983, seven cases of AIDS are diagnosed in BC.

- The Barriere and District Diagnostic and Treatment Centre and Cassiar Hospital open.

1984

- The Canada Health Act is passed by Parliament and receives Royal Assent.
- Tumbler Ridge Health Centre opens.
- The Greater Victoria Hospital Society is formed.

1986

- Valemount Diagnostic and Treatment Centre opens.
- The Sechelt Band embarks upon self government.
- The federal government announces the Health Transfer Program to shift control of Native health care to Native councils.

1988

- The UBC Health Sciences Centre and the Shaughnessy Hospital merge to form University Hospital.
- BC passes mandatory legislation to regulate nursing practice. The amending of the Nurses' (Registered) Act requires mandatory registration of all nurses and gives the Registered Nurses Association the power to implement registration and renewal requirements.
- A needle exchange program is initiated in Vancouver in an effort to reduce the spread of AIDS.
- Chase Diagnostic and Treatment Centre opens.

1990

- The British Columbia Royal Commission on Health Care and Costs is established.
- Vancouver becomes the first Canadian city to provide regular bus service for the disabled, with wheelchair accessible (lift-equipped) buses.

1991

- The provincial government grants $1.2M for the construction of BC's first Women's Health Centre at University Hospital, Shaughnessy Site.
- The Provincial Surgical Registry is opened.
- The St. Vincent Health Care Society is formed.
- The Report of the Royal Commission on Health Care and Costs is tabled.

Toward Tomorrow

There are very few people as fortunate in their history and institutions as British Columbians. There are very few people that share our general level of prosperity, freedom, or good health. Vast geographical distances separate communities, and yet there is a sense of being British Columbians, of being the inheritors of a magnificent common wealth.

The health care system that this province and country have worked to build is part of that common wealth. It is one of the things that make us who we are. But the successes of medicare – the removal of financial barriers to care and the establishment of care as a right – can blind us to the possibilities inherent in new approaches to health.

We are faced with the challenge of determining the health requirements of a complex society. The challenges are not insurmountable. Building a more equitable and integrated system of care may be the greatest contribution British Columbians could make to the future of Canada.

● Communities visited during public hearings
▲ Other communities visited by Commissioners
WHITEHORSE
Juneau
Wrangell
Ketchikan
Dixon
Prince Rupert
PORCHER I
Hecate Strait
Queen Charlotte Sound
VANCOUVER ISLAND
Ucluelet
PACIFIC RIM
Juan de Fuca
C Flattery
Rainbow Lakes
A
SILEGAR, FORT NELSON, TERRACE, KELOWNA, GRAND FORKS, QUESNEL, CASSIAR, BURNAB
FORT ST. JOHN, MASSET, VERNON, DELTA, MAPLE RIDGE, TRAIL, ABBOTSFORD, NEW
WILLIAMS LAKE, DAWSON CREEK, ROSSLAND, SIDNEY, CECIL LAK
SECHELT, PORT HARDY, WEST VANCOUVER, SOUT
GOLD RIVER, GOLDEN
WHISTLER, PENTICTON
QUALICUM BEACH
NS LAKE, KEREMEO
NELSON, TERRAC
T ST. JOHN, MASSE
HILL, WILLIAMS LAK
DS, CAMPBELL RIVE
ROCK, PEACHLAN
LILLOOET, GIBSON
LAKE, VALEMOUN
GLISLA, DEASE RIVE
NCE GEORGE, SURRE
ODY, SALMON ARM
AM, MISSION, NORT
TA, HALF MOON BA
LOWKNIFE, MCBRID
TUMBLER RIDGE, NEW
WINFIELD, LADNE
ROSEDALE, YARROW
PRINCE RUPER
TOKE, COMO
NANAIMO
MERRIT
PO
QUE
KIMBE
ALBERNI
MCNEILL
ASHCRO
OF, MADEI
SALTSPRIN
OUV
RT
SE
KE, D
SECHEL
RWATER, D
RIOLA ISLAND, W
ANK, BLACK CREE
GENSBORG, UCLUE
NELSON, CASTLEG
ILLIWACK, KAMLOOPS
VANCOUVER, KITIMAT
Y, MACKENZIE, GARIBALDI
ANICHTON, FERNIE, NAKUSP
W DENVER, INVERMERE, 100 MI
WASSEN, TELKWA, DEASE LAKE, FRA
MATA, FORT ST. JAMES, LUMBY, WAGLISL
NSBORG, UCLUELET, BURNS LAKE, KEREMEO
VICTORI
FORT NELSON, TERRAC
QUEEN CHARLOTTE CITY, PORT MOODY, SALMON ARM, CHILLIWACK, KAMLOOPS, FORT ST. JOHN, MASS
KIMBERLY, ALERT BAY, COQUITLAM, MISSION, NORTH VANCOUVER, KITIMAT, COBBLE HILL, WILLIAMS LA

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